Event will begin soon!

WELCOME

Self-Insurance Colloquium 2025

November 13, 2025
8:30 AM – 12:30 PM

Technical difficulties?

- Please use the chat option or email SIColloquium@LNI.WA.GOV

OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

Self-Insurance Colloquium 2025

November 13, 2025 Webinar

Stephanie Scheurich

Washington State Department of Labor & Industries

Mission Statement

The Department of Labor and Industries (L&I) Self-Insurance Colloquium is a collaboration of the self-insured workers' compensation community to promote worker wellness by encouraging health care best practices, health systems improvements and innovations, and high quality, evidence-based medical treatment.

The self-insured community, through the Washington Self-Insurance Association, collaborates with L&I to review updates on medical policy issues and occupational health best practices.

Stephanie Scheurich
Washington State Department of Labor & Industries

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Safety Tip

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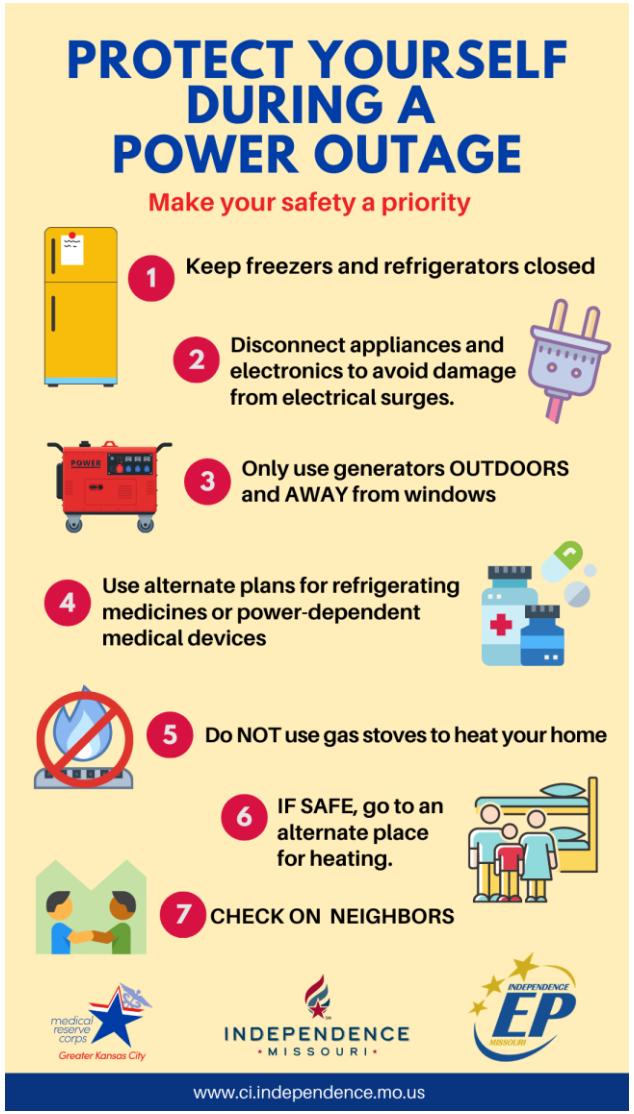

Image courtesy of www.mrcgkc.org

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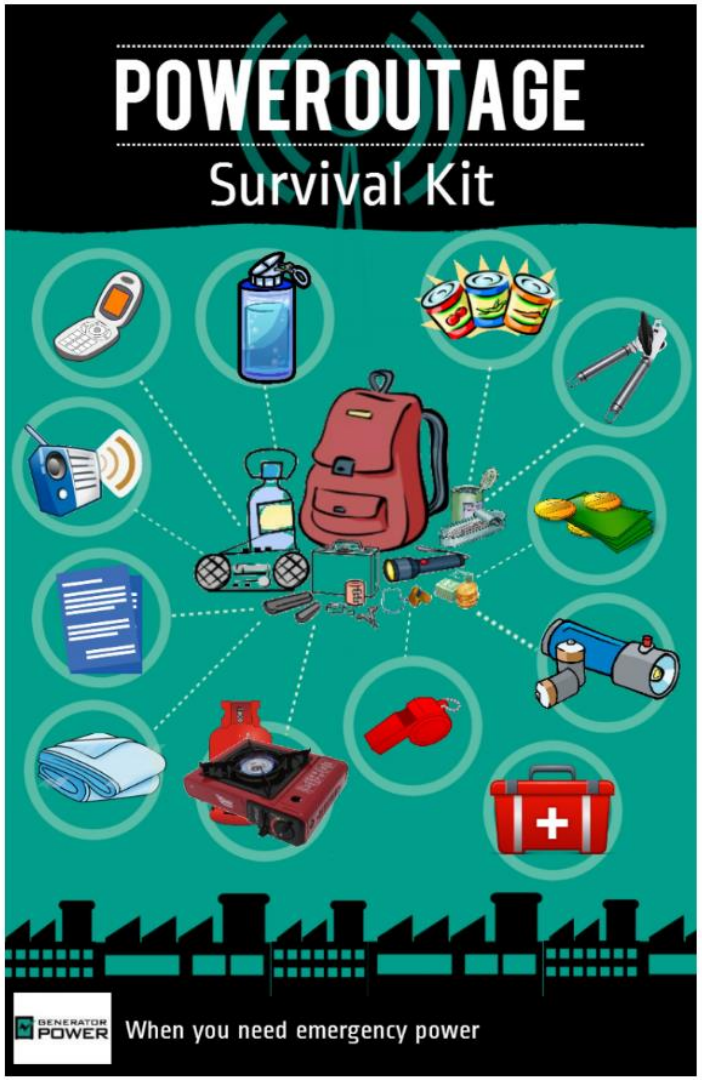

Look at our Power Outage Survival Kit-these essential items could help make the duration of any power outage more bearable.

Our essential survival kit includes:

- Water
- Non-Perishable food
- Can opener
- Phone
- Wind up or battery powered radio
- Wind up or battery powered torch
- Cash
- Contact information and important documents
- Blankets
- Whistle
- First aid kit
- Gas Stove and fuel

There are a number of other survival items that can make your stay without power bearable- from board games to extra clothing, heaters and more.

Image courtesy of generator-power.co.uk

Stephanie Scheurich
Washington State Department of Labor & Industries

Virtual Housekeeping

- The Q&A and Chat options are located at the bottom middle of your Zoom window.

- The Chat option will be turned off when the first presentation begins and remain off for most of the webinar.
  - For help with technical difficulties, email SIColloquium@lni.wa.gov.

- To ask presentation questions, please use the Q&A option.
  - Questions will be answered verbally, written in the Q&A window, or saved for review after the event ends.

- Staff will monitor the chat, Q&A, and SIColloquium@lni.wa.gov email during today's event.

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Description of the Day's Topics

Stephanie Scheurich

Washington State Department of
Labor & Industries

Time	Topic
8:30 – 8:40	**Welcome and Orientation** • Safety Tip • Webinar Housekeeping Rules • Description of the Day's Topics • Continuing Education Information - Requirements
8:40 – 10:10	**Bending the Quality Curve: An Overview of Strategies L&I Uses to Ensure the Quality of Care in Workers' Compensation** • Introduction • Provider Management • Provider Support & Outreach • Centers of Occupational Health and Education (COHE)
10:10-10:20	**10 Minute Break**
10:20-10:50	**Lumbar Fusion/Spinal Surgery Update**
10:50- 11:35	**Structured Intensive Multidisciplinary (Pain) Program Update**
11:35-11:45	**10 Minute Break**
11:45-12:05	**Stump the Docs - Panel Discussion and Q&A** • Occupational Disease, Causation, and Chemically Related Illness
12:05-12:15	**Closing** • Continuing Education Information - Requirements • Remarks and Takeaways
12:15-12:30	**Continuing Education Survey Guidance**

Continuing Education Credit Information

Course Title: Self-Insurance Colloquium 2025

1. This course has been pre-approved by L&I's Self-Insurance Continue Education Curriculum Advisory Committee to provide continuing education credit for completion of the identified course.
   - The course is approved for **3.0** CE contact hour(s).
   - Course ID number: **004-1125-0385**
   - Course Approval Number: **WA2025-474**

2. This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CDMS® board-certified disability management specialists.
   - The course is approved for **3.0** CE contact hour(s).
   - Activity code: **S00001535**
   - Approval Number: **250000345**

Please note:

- **Attendees must complete the Post Event Evaluation/Survey to receive a Certificate of Completion.**
- Post Event Evaluations/Surveys will be sent tomorrow via your registration email.
- **The Evaluation/Survey must be completed by December 12, 2025.**
- Certificates of Completion will be emailed after the Post Event Evaluation/Survey window closes.

Questions: SIColloquium@LNI.WA.GOV

Attendance will be verified by Zoom registrant generated reports.

James Simonowski
Suzyn Daniel
Washington State Department of Labor & Industries

OCCUPATIONAL HEALTH **BEST PRACTICES**

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Bending the Quality Curve: An Overview of Strategies L&I Uses to Ensure the Quality of Care in Worker's Compensation

Karen Jost, Tim Martinen, Teri Baughman, Zack Mills, Espen Pyrtek, Wyndi Herrera, and Timothy Robinson

Washington State Department of Labor & Industries

Today's Presenters

- **Introduction**
  Karen Jost, Health Services Analysis Program Manager

- **Provider Management**
  Tim Martinen, Provider Accounts and Credentialing Manager
  Teri Baughman, BSN, RN, Occupational Nurse Consultant Supervisor

- **Provider Support & Outreach**
  Zack Mills, Medical Program Specialist
  Espen Pyrtek, Medical Program Specialist

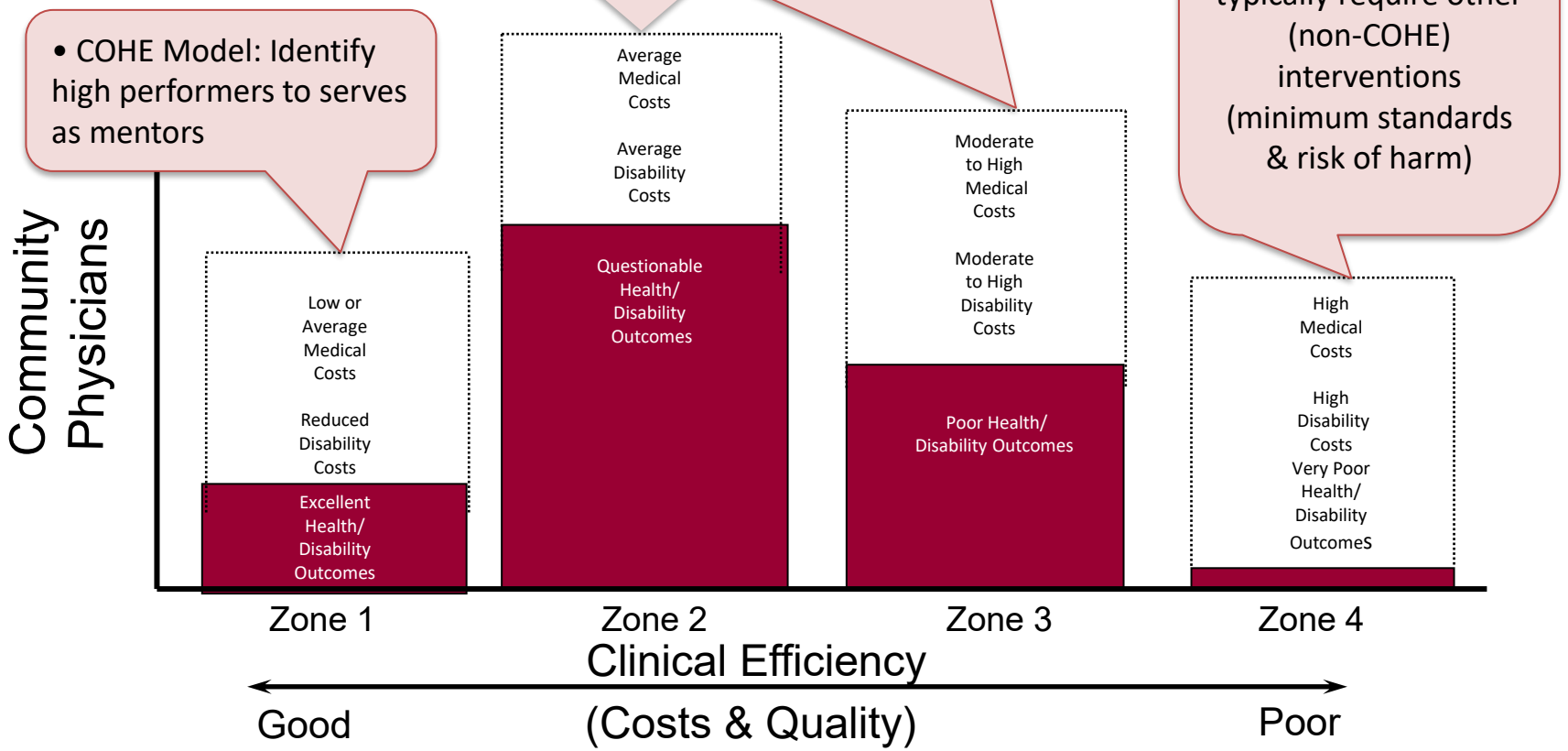
- **Centers of Occupational Health and Education (COHE)**
  Wyndi Herrera, Medical Program Specialist
  Timothy Robinson, Medical Program Specialist

Distribution of Quality of Care

- Incentives for quality indicators known to improve outcomes
- Resources to help docs apply them (CME, HSCs, reminders)
- Geared toward improving well-intentioned Zone 2 & 3

• COHE Model: Identify high performers to serves as mentors

Patterns of poor-quality care that presents injured workers a risk of harm typically require other (non-COHE) interventions (minimum standards & risk of harm)



OCCUPATIONAL HEALTH **BEST PRACTICES**

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Provider Management

Tim Martinen
Teri Baughman

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L&I Network Eligible Providers

- Physician (MD)
- Osteopathic Physician (DO)
- Podiatrist (DPM)
- Naturopathic Physician (ND)
- Physician Assistant (PA)
- Advanced Registered Nurse Practitioner (ARNP/CRNA)
- Dentist (DDS/DMD)
- Chiropractor (DC)
- Optometrist (OD)
- Psychologist (PHD/PsyD)

Image courtesy of PowerPoint

Tim Martinen
Teri Baughman
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Initial Enrollment- Review of Network Application

- Licensure/Certification verified
- Attestation reviewed for completeness/accuracy
- Office of Inspector General exclusion list is checked
- Enrolled in National Provider Data Bank continuous monitoring (NPDB)
- Lexis Nexis background check for malpractice/criminal history

Image courtesy of PowerPoint

Tim Martinen
Teri Baughman
Washington State Department of Labor & Industries

Ongoing Provider Monitoring

- National Provider Data Bank (NPDB) notifications
- Lexis Nexis background check
- Department of Health (DOH) suspension/revocation reports
- DOH monthly license upload

Image courtesy of PowerPoint

Tim Martinen
Teri Baughman
Washington State Department of Labor & Industries

Resources Available for Self-Insured Employers

Provider Network Status Look Up

Look up an individual provider by National Provider Identifier (NPI) or L&I Provider Number.

Note: When using the lookup tool see the Payment History Status for the effective date to bill for ongoing care.

Provider Network Status Report

Report detailing all providers that are participating in L&I's Network.

Network History

Effective Dates	Current Network Status	Payment Status
8/10/2018 - 12/31/2099	Participating (07)	Initial and ongoing treatment is payable.
7/9/2018 - 8/9/2018	Application Received (02)	Only initial visit is payable.
1/1/2013 - 7/8/2018	Not in the network (05)	Only initial visit is payable.

Payment History Status

Effective Dates	Current Network Status	Payment Status
7/9/2018 - 12/31/2099	Participating (07)	Initial and ongoing treatment is payable.

Tim Martinen
Teri Baughman
Washington State Department of Labor & Industries

Provider Quality Assurance

What We Do

L&I Agency Goal 2:

- Ensure that network providers are helping injured workers heal and return to work

Our approach:

- Assure that our MPN providers deliver and meet treatment guidelines/standards of care, and treatment is curative in nature (goal oriented)
- Monitor the quality of Independent Medical Exams (IMEs)

Tim Martinen
Teri Baughman
Washington State Department of Labor & Industries

L&I Medical Provider Network (MPN)

- Approximately 33K active providers in MPN
- < half actively treating workers
  - 60% physician
  - 4% chiro
  - 3% dentist

- Quality Reviews leading to termination: 144 since 2013
  - 124 DOH enforcement action
  - 6 medical license expiration
  - 6 prescribing
  - 3 malpractice history

Tim Martinen
Teri Baughman
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Provider Quality Complaint Intake

- Concerns re: provider care (ProviderComplaint@lni.wa.gov)
- IME Complaints (IMEComplaints@lni.wa.gov)
- No wrong door; we accept any and all complaints and triage to appropriate area i.e. worker fraud, claim suppression, billing dispute
- Complaints received from internal staff, third party administrators, workers, etc

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Teri Baughman
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CY 2024: A Year In Review

- Total logged referrals/complaints: 335
  - Comagine Chronic Opioid Therapy - 9
  - Department of Health (DOH) - 23
  - Email inbox - 47
  - New Applications with adverse actions - 12
  - National Provider Databank (NPDB) alerts - 166
  - Opioid death - 50
  - Other - 28
    - Other payer terminations i.e. Medicaid, other issues

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Triage Complaints

Provider Quality Compliance

- Prescribing issues
- Poor health outcomes
- Non-adherence to treatment guidelines
- Insufficient documentation to support treatment/lack of treatment plan
- Failure to disclose enforcement or malpractice actions

Other Concerns

- Claim management
- Claim suppression
- Claim closure
- Denial of authorization request
- Billing fraud, waste, and abuse

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Teri Baughman
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Provider Credentialing Committee

- Panel of peers includes panelist(s) with same degree and specialty of provider being reviewed
- All pertinent documents are reviewed
- Recommendation made pertaining to approval or denial (new applicants) or other enforcement (approved providers, up to and including termination)
- Cite appropriate Provider Network Rule(s) WAC violations
- Provide recommendations to Dr. Gary Franklin, LNI Medical Director who makes final decision

Tim Martinen
Teri Baughman
Washington State Department of Labor & Industries

Provider is Denied or Termed from Network

- Provider being reviewed can request reconsideration
- Reconsideration documents are reviewed by Credentialing Committee
- Panel makes recommendation to Medical Director
- If initial decision is upheld, provider can appeal to BIIA

This process can take multiple months to complete

Tim Martinen
Teri Baughman
Washington State Department of Labor & Industries

Education and Outreach - Example

- Primary focus on assisting providers

- Claims Occupational Nurse Consultant (ONC) referral concerning provider not following opioid prescribing guidelines

- Provider Quality sent education letter to prescriber asking for response; none provided:
  - Solicited Field ONC to intervene resulting in worker getting into detox and structured intensive multidisciplinary program (SIMP) treatment
  - Field ONC coordinated care and worker returned to work

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Independent Medical Exam (IME) Clinical Quality Assurance Efforts

IME quality reviews by Occupational Nurse Consultant:

- New examiners – a sample of IME reports are reviewed twice in the first year of practicing IMEs
- Re-credentialing Examiners – a sample of IME reports are reviewed in conjunction with the 3-year recertification cycle
- A feedback letter is sent to the examiner and firm of findings related to Impairment Ratings, Non-billable addendums, and whether required content was contained in the IME report
- A larger sample of reports may be reviewed if there are concerns found during the review or if there is a trend of complaints
- An IME Review Team meets monthly to discuss issues

Tim Martinen
Teri Baughman
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How to Measure Impact of Quality Efforts?

- Improved health outcomes for workers
- Reduction in referrals for quality concerns
- Understand and identify drivers of quality
  - Common provider (attending or ancillary)
  - Poor documentation
  - Volume of patients
  - Worker satisfaction

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OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

Provider Support & Outreach

Zack Mills
Espen Pyrtek

Washington State Department of
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Provider Support and Outreach

Who We Are

Team of eight with expertise in:

- Claim management
- Bill payment
- Provider experience (non-clinical)
- L&I systems and processes

Zack Mills
Espen Pyrtek
Washington State Department of
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Our Role

- Connect with providers and humanize L&I
- Act as liaison with providers
  - Help providers with L&I questions and issues
  - Bring provider perspective to L&I
- Listen to providers
  - Help define and resolve problems
  - Acknowledge and verify concerns
- Teach administrative side of workers' compensation

Zack Mills
Espen Pyrtek
Washington State Department of
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Topics

How to:

- Become an L&I provider
- Document services and complete forms
- Bill for services
- Understand and follow administrative processes
    - For example: pre-authorization

Zack Mills
Espen Pyrtek
Washington State Department of
Labor & Industries

Our Methods

- Conduct billing workshops
- Exhibit at professional conferences
- Provide customized workshops or presentations for healthcare organizations
- Consult with providers via phone, email, and Teams
- Connect providers to other L&I staff
- Assist providers outside of the United States

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Espen Pyrtek
Washington State Department of
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Additional Methods

- Develop and maintain supportive tools
  - Quick Reference Fee Cards
  - Provider Directory (Find-A-Doc)

- Develop policy
  - Subject matter experts on projects and teams
  - Advise policy teams of needed changes/clarifications
  - Provide project management skills

Zack Mills
Espen Pyrtek
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Current Project Example

Proactive Outreach Project

- Project Charter signed 2024

- Proactive Outreach Project Goals
  - Help orient new L&I providers
  - Offer new providers support and resources early
  - Build relationships with new providers so they know who to contact when they have questions

Zack Mills
Espen Pyrtek
Washington State Department of
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What We Want You To Know

We help providers and their staff resolve complex problems so that it's easier to do business with L&I.

Zack Mills
Espen Pyrtek
Washington State Department of
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When To Contact Us

- Provider education regarding
  - Applications/becoming an L&I provider
  - Documentation/charting/forms
  - Billing policy
  - Pre-authorization requests and requirements
  - Communication

- Please send an email to ProviderSupport@Lni.wa.gov for questions, concerns, or assistance

Zack Mills
Espen Pyrtek
Washington State Department of
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OCCUPATIONAL HEALTH **BEST PRACTICES**

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Introduction to Centers of Occupational Health & Education (COHE)

Wyndi Herrera
Timothy Robinson

Washington State Department of
Labor & Industries

Today's Focus

- Why COHE exists?
- What is COHE?
- Who are the key players?
- What are the core services and best practices?
- What are the benefits and impacts?
- How can I help or be involved?

Wyndi Herrera
Timothy Robinson
Washington State Department of
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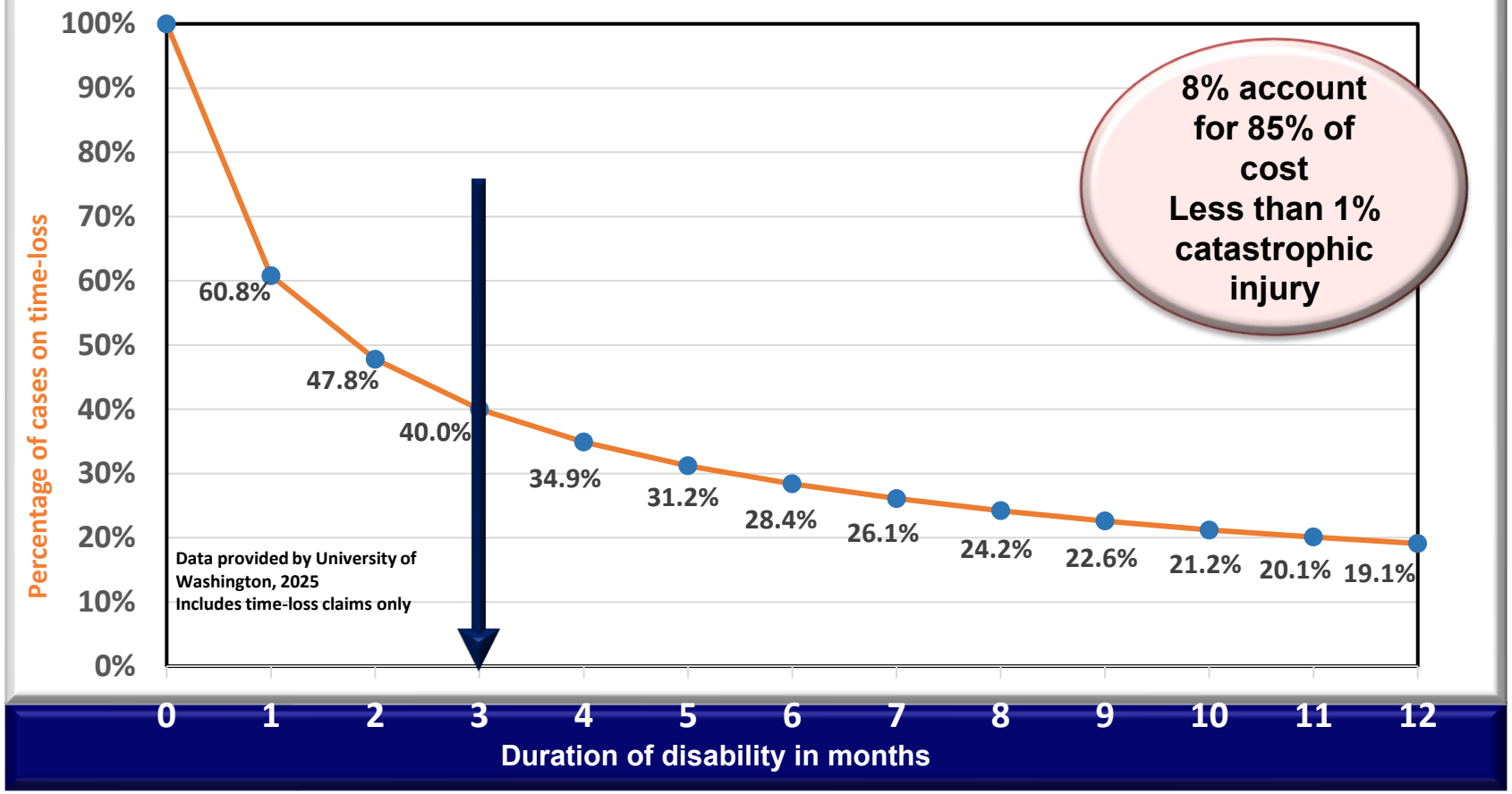
Workers' Comp Reality

Percentage of time-loss claims with duration beyond given month

Average of fiscal accidents years 2010-2018



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Wyndi Herrera
Timothy Robinson

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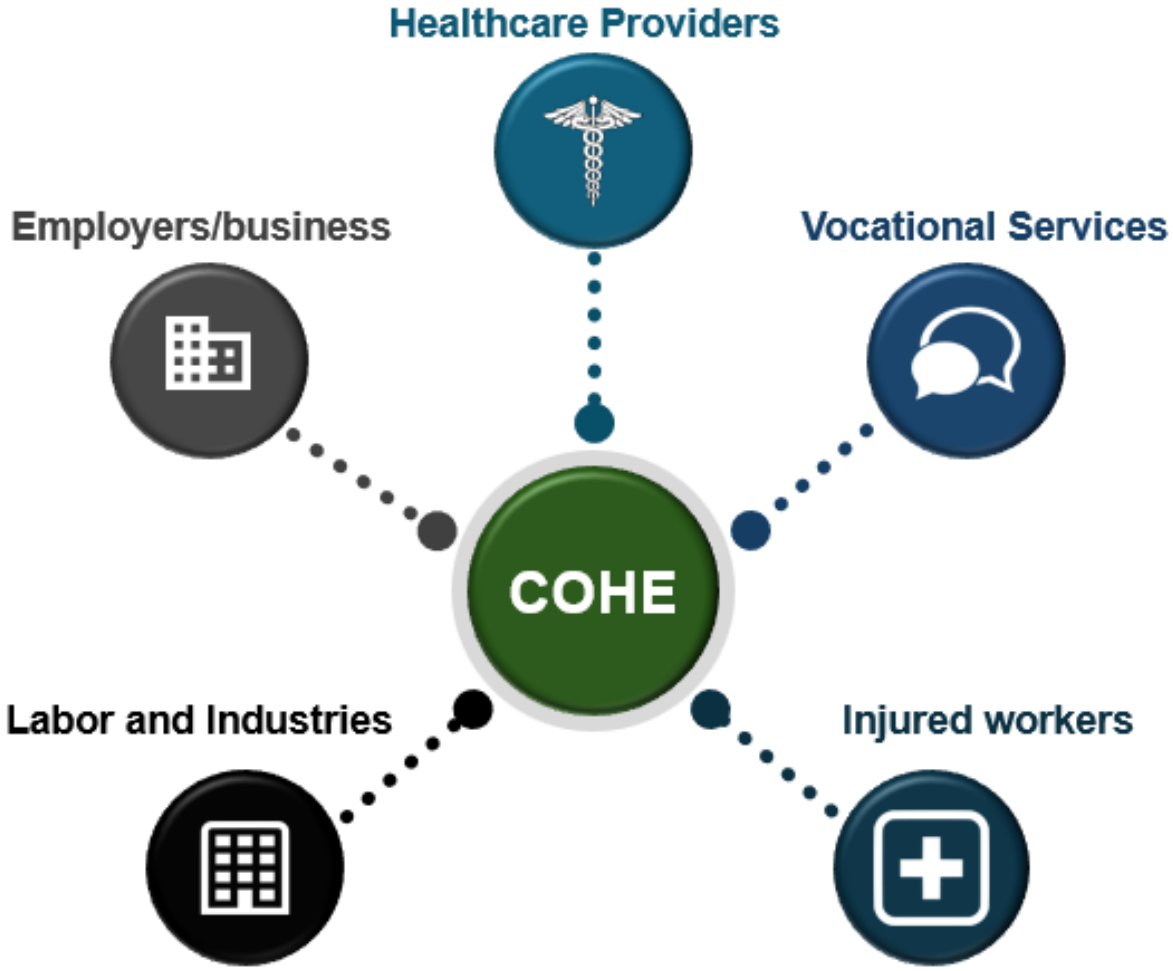
What is a COHE?

Reduction in long-term disability for injured workers through occupational health best practices



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Timothy Robinson
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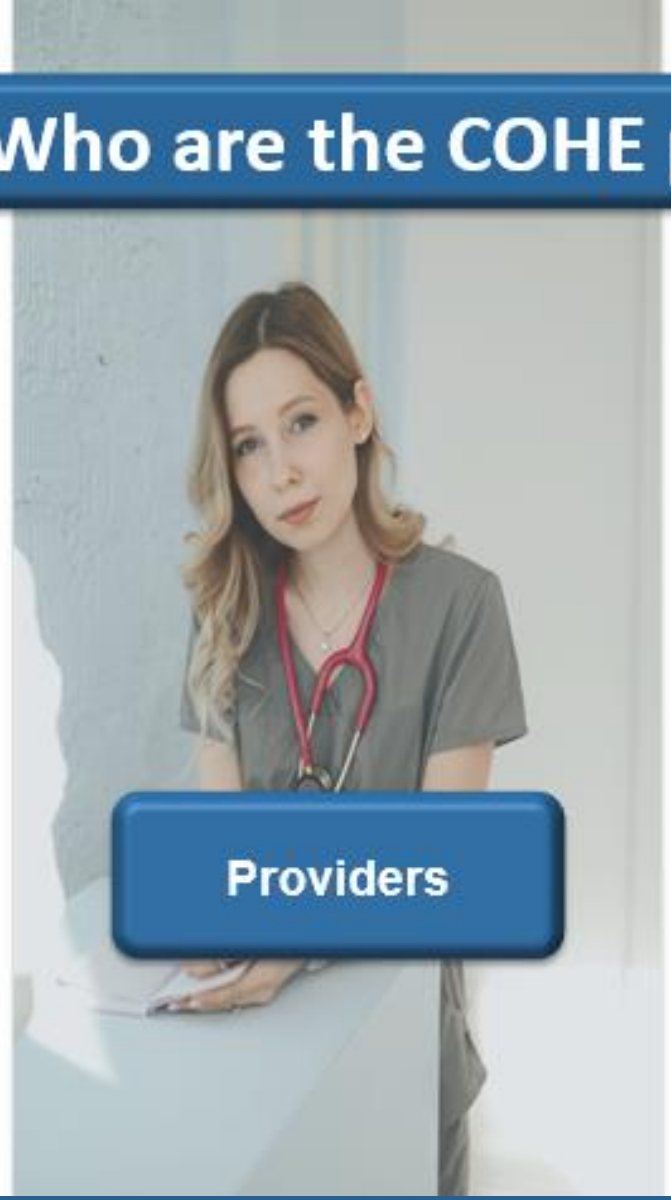
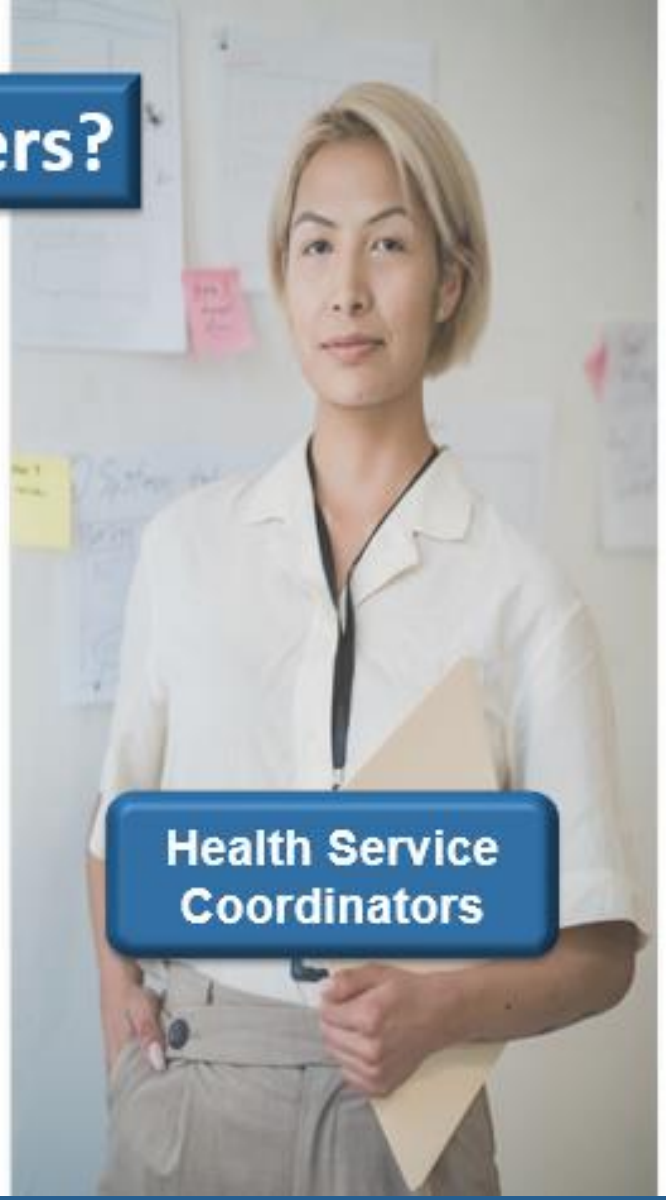
Who are the COHE players?



Providers



Health Service Coordinators

Advisor Panel

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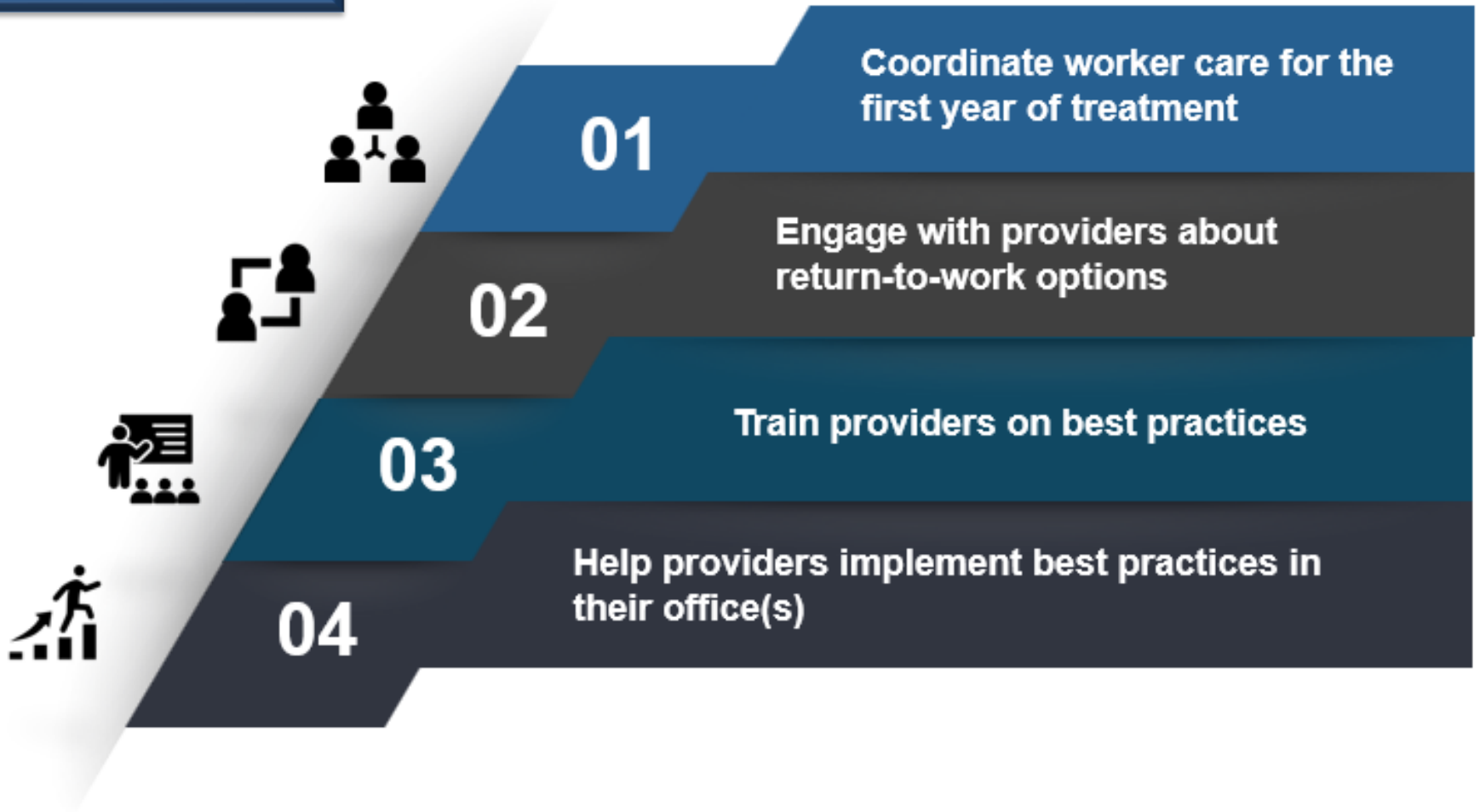
Core COHE services



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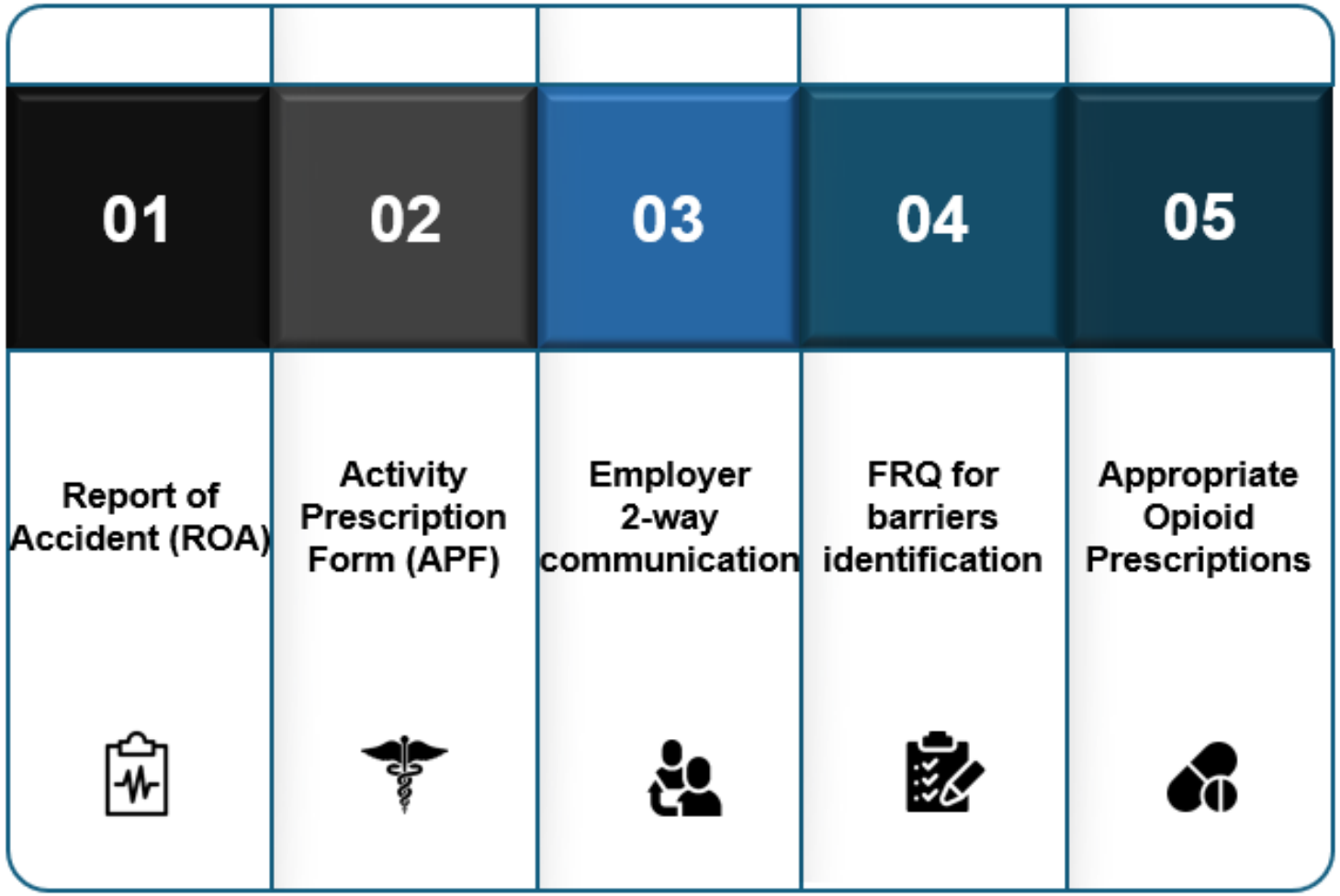
COHE Occupational Health Best Practices



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Timothy Robinson
Washington State Department of Labor & Industries

Why COHE Best Practices?

COST SAVINGS

- ~$3,000 total cost per claim, which represents 14% less than non-COHE claims*

LOWER DISABILITY

- Average 9 fewer disability days**

* 2007 UW Evaluation Report, Thomas Wickizer
** 2020 L&I Actuaries

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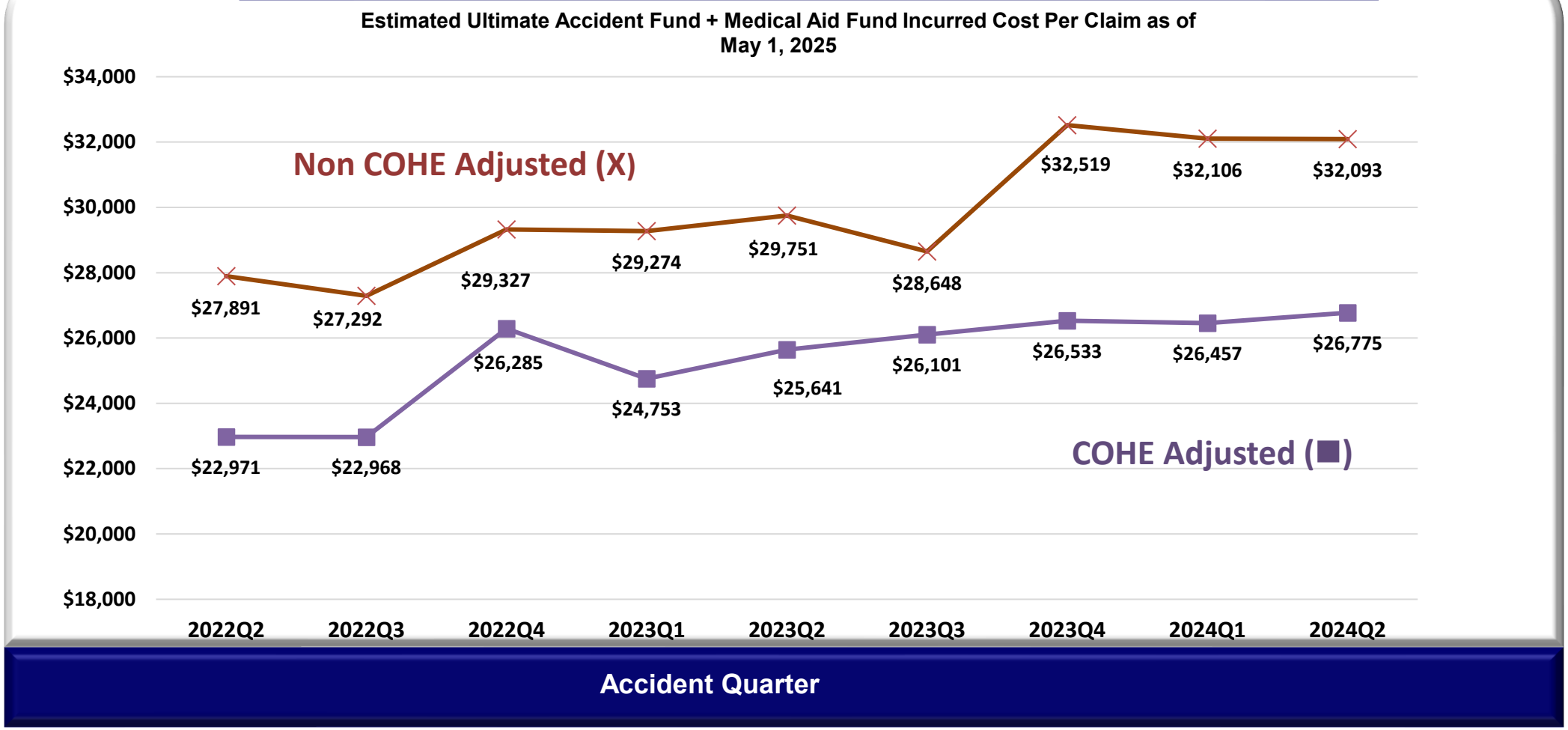
COHE Savings in More Detail



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Timothy Robinson

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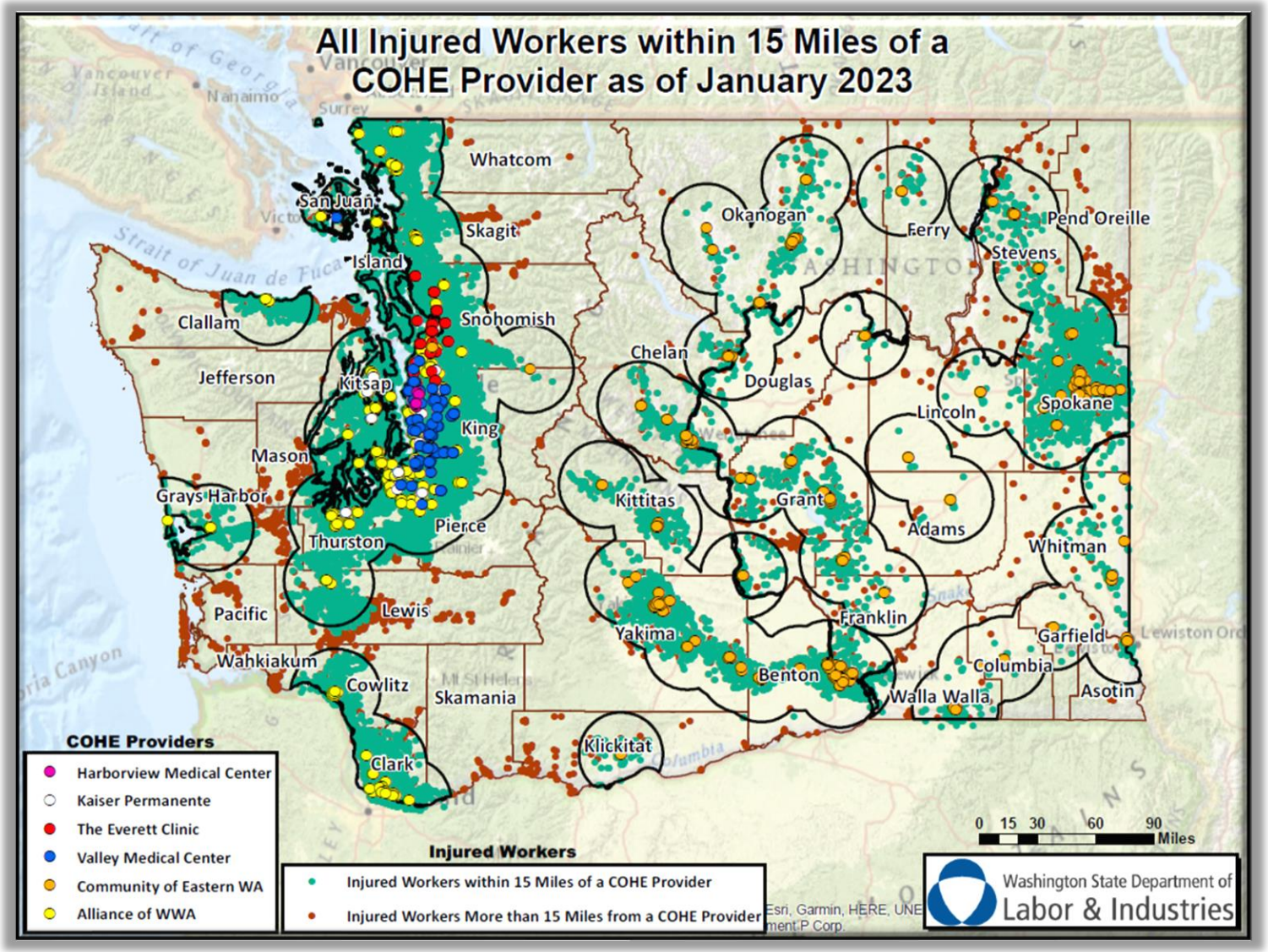
COHE Coverage

98% of WA workers are within 15 miles of a COHE provider



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Timothy Robinson

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RECAP

01

What is COHE?

- A quality improvement program that seeks to assist workers within the first three months of injury, and to continuously educate providers.

02

Benefits of COHE

- Reduce work related disability.
- Decreased claim costs.
- Improve medical and work recovery outcomes.

03

COHE Benefits achieved through

- Occupational health best practices.
- Health Services Coordination (HSCs).
- Provider training.

04

Who are HSC's?

- Work within a COHE to directly assist workers and providers.
- Can be viewed as an extension of the provider, helping workers navigate the workers' comp system.

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Timothy Robinson
Washington State Department of
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COHE-SI Partnership

Previous Partnership:

In 2012, COHE partnered with King County for a pilot at UW Valley, to improve health services coordination. The pilot ended in 2015 due to communication and technology challenges

Current Actions:

Our team has been collaborating with the internal Self-Insurance team to identify gaps between COHE and SI.

Request for collaboration:

We're inviting self-insured employers to collaborate, sharing your insights to help make this a more effective system that supports self-insured workers and their recovery.

Image courtesy of VectorStock.com

Wyndi Herrera
Timothy Robinson
Washington State Department of Labor & Industries

Question & Answer Session

Images courtesy of PowerPoint

Wyndi Herrera
Timothy Robinson
Washington State Department of
Labor & Industries

Contact Us

Introduction/Distribution of Quality Care

- Karen Jost, Karen.Jost@lni.wa.gov

Provider Credentialing & Quality Assurance

- Tim Martinen, Tim.Martinen@lni.wa.gov
- Teri Baughman, BSN, RN, Teri.Baughman@lni.wa.gov

Provider Support & Outreach

- ProviderSupport@Lni.wa.gov

Centers of Occupational Health and Education (COHE)

- Wyndi Herrera, Wyndi.Herrera@lni.wa.gov
- Timothy Robinson, Timothy.Robinson@lni.wa.gov

OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

10 Minute Break

Reminder: Stay logged in at the end of the Colloquium for a brief presentation on how to earn CE's.

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OCCUPATIONAL HEALTH **BEST PRACTICES**

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Lumbar Fusion/Spinal Surgery Update

Gary M. Franklin, MD, MPH
Medical Director, L&I; Research Professor, UW

Shauna Muendel, MPA, BSN, RN
Utilization Review Program Manager

Washington State Department of
Labor & Industries

WA State Authority for Evidence-Based Decisions

2003-SSB 6088-Established the Prescription Drug Program for all agencies-uses evidence within drug classes to determine coverage

2003-SHB 1299-all agencies to conduct formal assessment of scientific evidence to inform coverage, track outcomes

2005-Budget proviso-Agencies to collaborate on coverage and criteria (guidelines)-**opioid dosing guideline** -June, 2010

2006-Gov request legislation-HB2575/SB6306 to establish **WA State Health Technology Assessment Program**

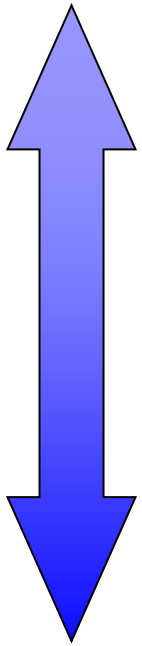
2011-HB 1311-Bree Collaborative: establishes public/private collaborative on guidelines and **research**, including anti-trust protection

2011-SSB 5801-Workers Comp Health Reform-includes authority to define harmful care; e.g., are you in the highest decile for failed lumbar fusion or reoperations?

Gary Franklin
Shauna Muendel
Washington State Department of Labor & Industries

Hierarchy of Evidence

Best: Meta-analysis of large randomized head-to-head trials.



Large, well-designed head-to head randomized controlled clinical trials (RCT):

- Long-term studies, real clinical endpoints
- Well accepted intermediates
- Poorly accepted intermediates

Smaller RCTs, or separate, placebo-controlled trials

Well-designed observational studies, e.g., cohort studies, case-control studies- CER studies

Safety data without efficacy studies

Case series, anecdotes

Least: Expert opinion, non-evidence-based expert panel reports, and other documents with no direct clinical evidence

Gary Franklin
Shauna Muendel
Washington State Department of Labor & Industries

Federal Oversight	Drugs	Medical Devices	Medical Procedures
Required for FDA approval	2 prospective, placebo controlled RCTs	"Substantial equivalence" to preexisting device	**No approval requirements**
Study outcomes	Disease-related endpoints	Engineering performance only	**None**
Published studies with patient-oriented endpoints?	Common	Uncommon	**Not Considered**
Patient population	Narrowly defined set of conditions (e.g., depression, dementia)	Varies widely (e.g., implantable defibrillators, laparoscopes)	**Not Considered**
Post-marketing evaluation?	Sporadic, sometimes high quality	Rare, usually low quality	**None**

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Shauna Muendel
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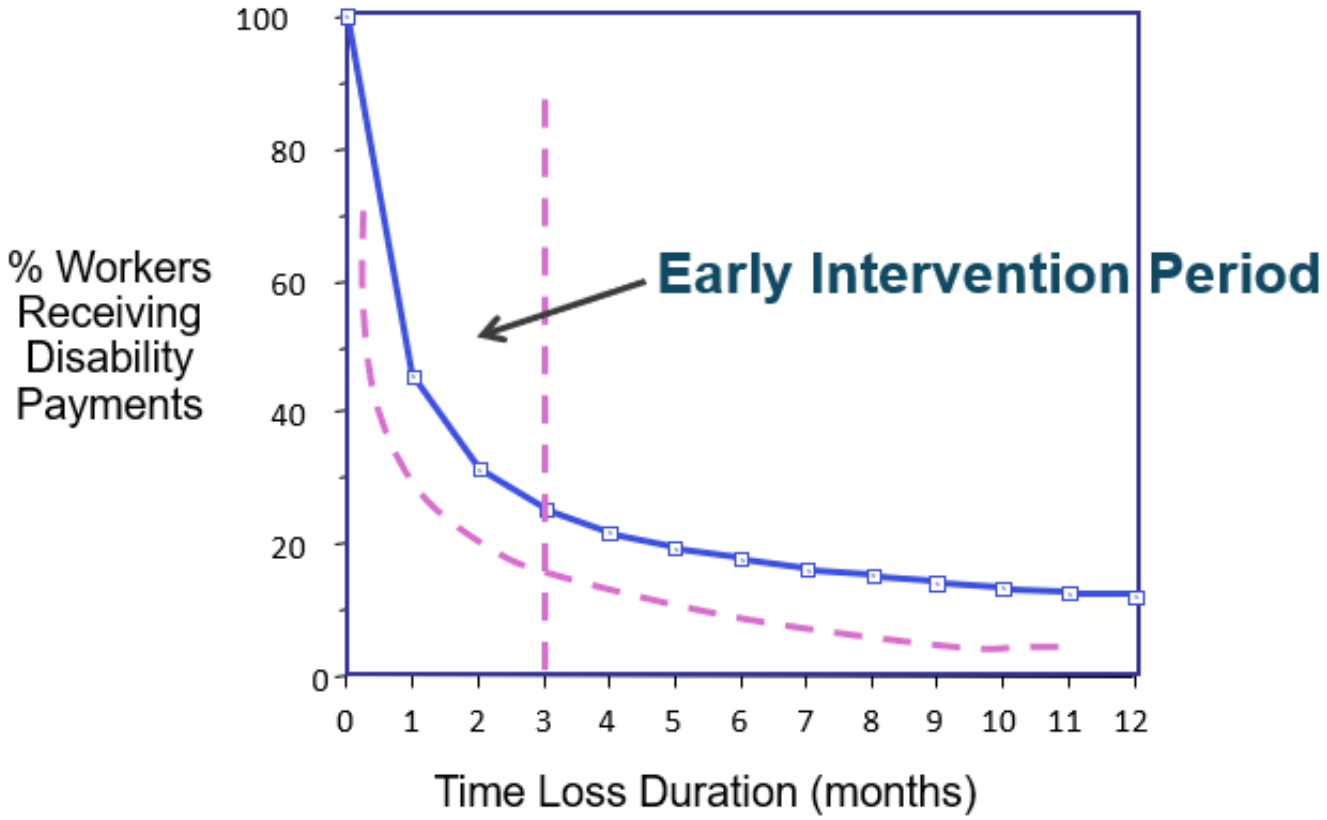
Changes in Disability Status among Injured Workers in WA State



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History of Medical Care in Workers' Compensation

- Some of the worst care in America-repeated surgery, inaccurate diagnoses, workers with rather simple injuries (backs, CTS) can become increasingly disabled while they are in workers' comp
- Outcomes of surgical procedures in workers comp far worse than in non workers comp - reasons unclear - 4-fold increased risk for unsatisfactory outcome:

  Harris et al, JAMA 2005; 293:1644-52

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What has Contributed the Most to Decades Long Pattern of Increased Disability Duration?

- **Use of harmful treatments, which contribute to prolonged disability: opioids, spinal surgery (lumbar fusion)**
  - **E.g., 44% of WA injured workers are totally disabled 10 years after lumbar fusion**
- **Multiple diagnosis problem (e.g., TOS)**
- **Bad docs**

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Workers' Compensation: Poor Quality Health Care and the Growing Disability Problem in the United States

Table II. Ultimate SSDI status for compensable cohorts 1997-2007

	Incident Claim Years	
	1997	2007
Percent compensable claims with SSDI by 2012	2.1%	2.9%
Percent compensable claims with SSDI or at risk for SSDI by 2012	5.4%	9.2%

Franklin et al, Am J Ind Med 2014 (Sept 30)

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WA Labor and Industries Specific Authority for Evidence-Based Decisions

- ESSB 5290-2007: **Industrial Insurance Medical and Chiropractic Advisory Committees**
- "…advise… on matters related to the provision of safe, effective, and cost-effective treatments for injured workers, including…development of practice guidelines and coverage criteria,…technology assessments, review of medical programs…"

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SSB 5801-2011-Medical Provider Network

- Our health care policies are THE standard for treatment in the WA workers compensation system
- “Network providers must be required to follow the department’s evidence-based coverage decisions and treatment guidelines, policies, and must be expected to follow other national treatment guidelines appropriate for their patient”

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Treatment Guidelines:
Examples of Treatment Guidelines

- Lumbar Arthrodesis (fusion) ~ 30-40% denial; requires demonstration of structural instability
- Thoracic outlet surgery – virtually non-covered, requires abnormal electrodiagnostic studies
- Carpal Tunnel Syndrome surgery – must have (+) electrodiagnostic studies [but do not allow portable electrodiagnostic tests, or psychophysical tests (quantitative sensory testing)]
- Proximal median neuropathy-requires specific objective abnormalities on electrodiagnostic testing; will stop extremely inappropriate treatment by just a few docs

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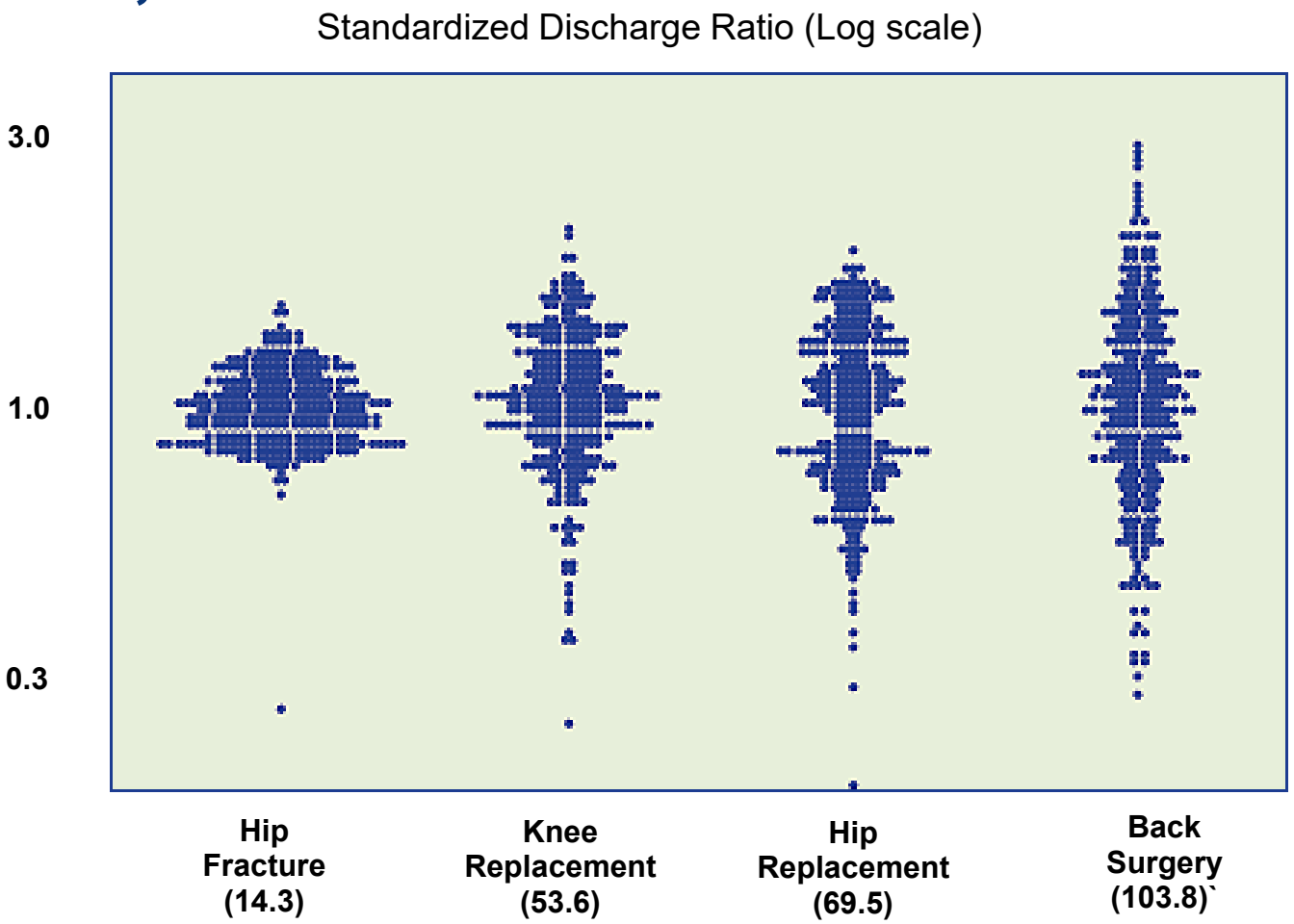
Rates of Four Orthopedic Procedures Among Medicare Enrollees, 2002 and 2003



Source: Dartmouth Atlas Project.

Source: Dartmouth Atlas of Health Care.

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Recent DLI Case

- Initial injury 7/5/99- **L3, L4, L5 laminectomy/foraminotomy**; RTW as trucker; Cat 3 PPD
- Injury 1/7/01
  - 9/25/01- **L5-S1 anterior lumbar interbody fusion** with BAK cages
  - 11/2/01-fusion revision requested
  - 8/13/03- **laminectomy redo L4,5,S1; L5-S1 instrumented fusion** based on ? Pseudoarthrosis
  - CAT 4 PPD (fusions + S1 radiculopathy)
  - 12/16/03-RTW trucking
- Injury 6/28/08
  - 6/24/09- **Removal L5-S1 hardware; exploration, decompression L4-S1**
  - 10/12/11- **L4,L5 laminectomy, Pedicle screw, transforaminal interbody fusion L4-5; intertransverse fusion L4-5 (Paid by another party since denied by Dept)**

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Washington State WC Fusion Outcomes

- **Franklin et al, 1994; Spine 20: 1897-903**
  N= 388 from 1986-87
  68% TTD at 2 years; 23% more surgery by 2 yrs
  Instrumentation doubled risk of reoperation
  Surgical experience didn't matter
  Key-WC fusion outcomes far worse than previously reported from surgical case series

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1992-DLI Lumbar Fusion Guideline

- No prior surgery
  - Measurable instability on flexion/extension xrays
  - Spondylolisthesis with measurable instability OR neurologic signs/symptoms
  - Only single level fusion with first surgery
  - No fusion if main problem is unilateral herniated disc and radiculopathy- decompression alone better (laminectomy, discectomy)

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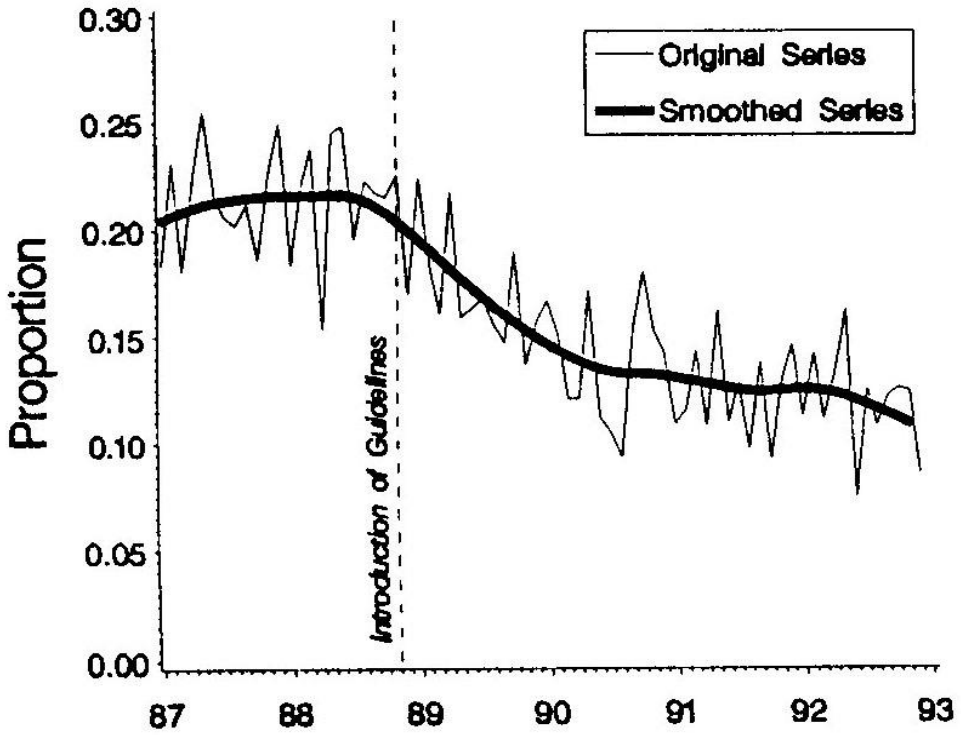
Lumbar Fusion Policy Translation

1992: tightened lumbar fusion guideline to include measurable instability; exclude pure "discogenic" back pain; exclude cases of acute disc herniation



Adapted from Elam et al. Medical Care 1997;35:417-424

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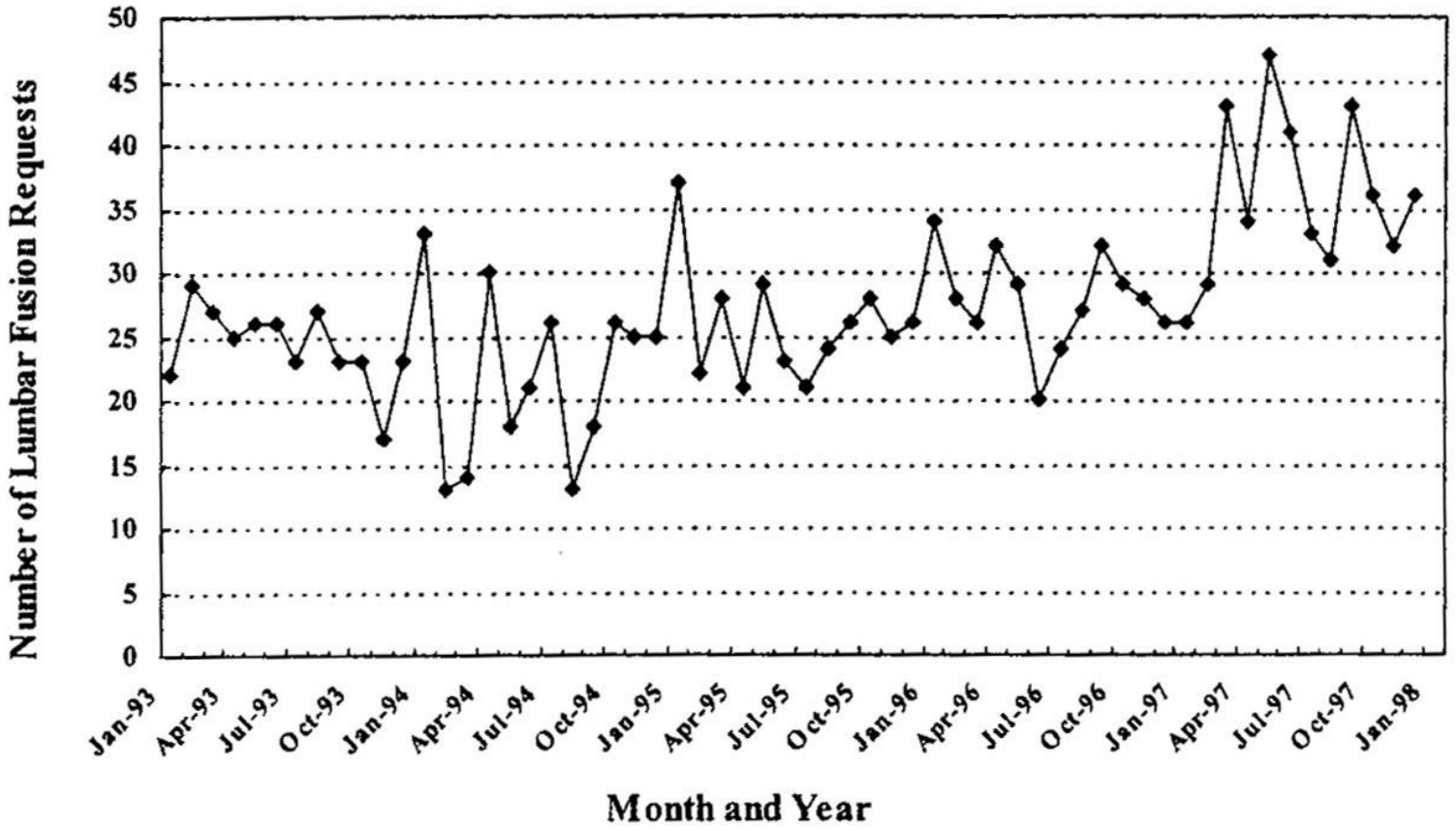
Lumbar Fusion-Effect of Rapid Diffusion of New Technology



Adapted from Franklin et al. Am J Man Care 1998;4:SP178-SP186

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Washington State WC Outcomes

Juratli et al, 2006; Spine 31:2715–23.

1950 fusion subjects from 1994-2000

85% received cages and/or instrumentation

64% disabled at 2 yrs; 22% reoperated by 2 yrs + 12% other complications

Cage/instrumentation use increased complications without improving disability or reoperation rate

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Juratli et al, Mortality (WC) after Lumbar Fusion Surgery, Spine 2009; 34: 740-47

- N=2378 fusions between 1994-2001
- Death records-103 deceased by 1994
- 90 day perioperative mortality 0.29%-assoc with repeat fusion
- Age and gender adjusted all cause mortality 3.1 deaths/1000 worker yrs
- **Opioid-related deaths 21% of deaths and 31.4% of potential life lost**
- Risk > with instrumentation/cages and DDD

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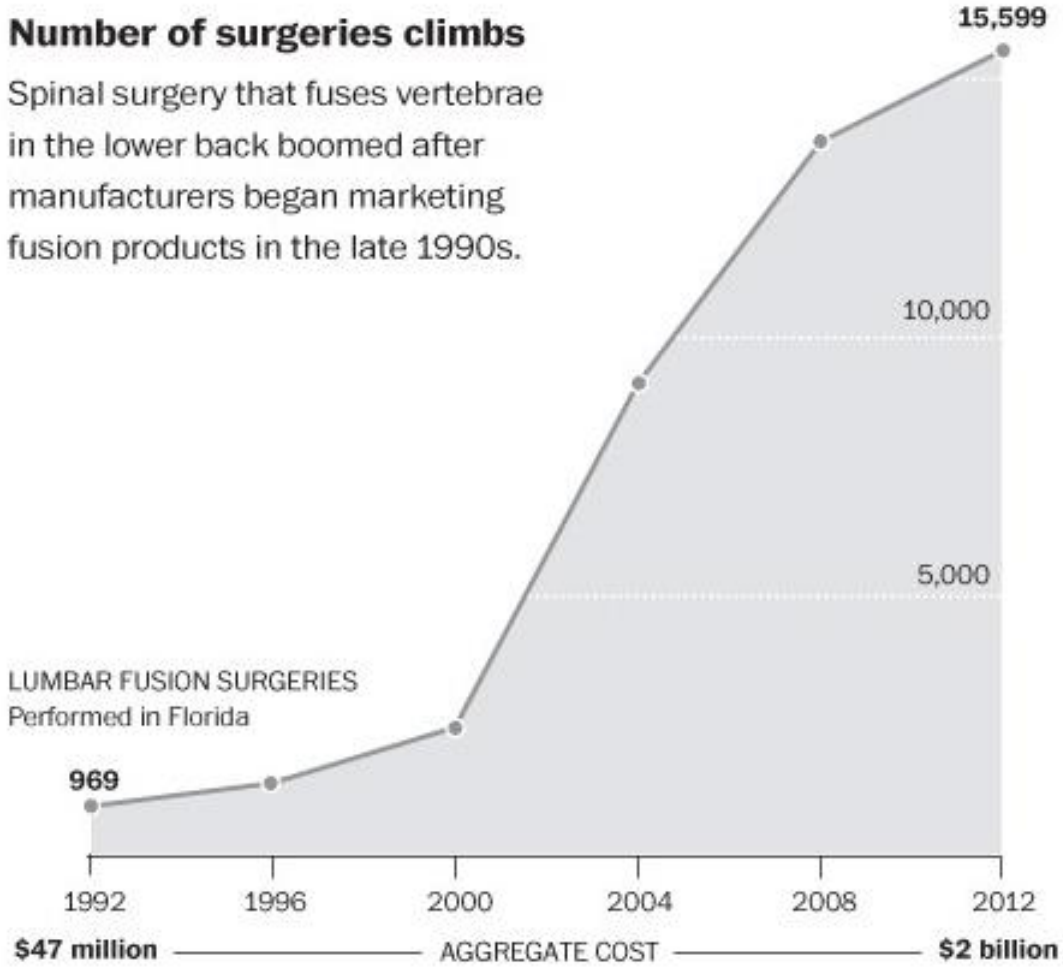
Washington Post 10/27/2013



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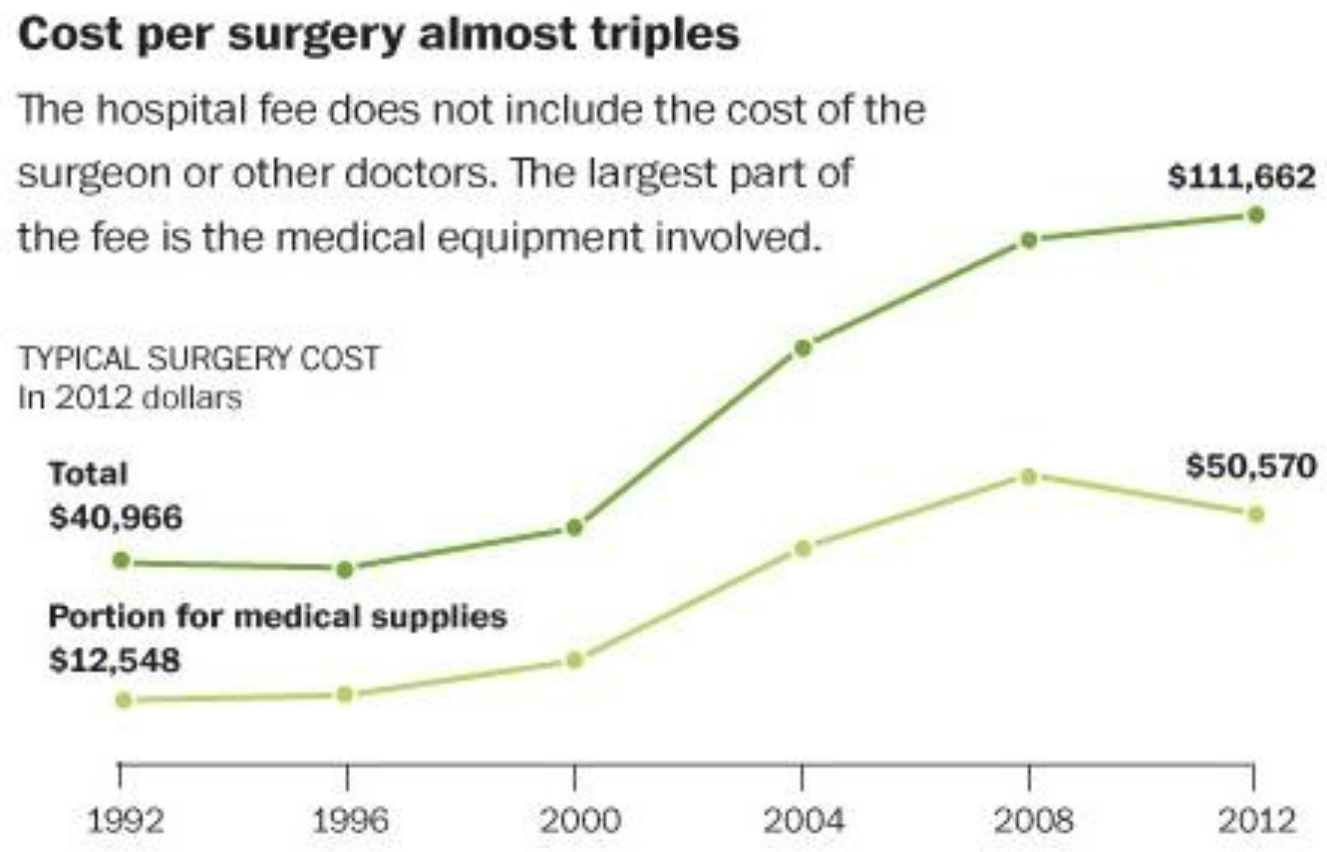
Washington Post 10/27/2013



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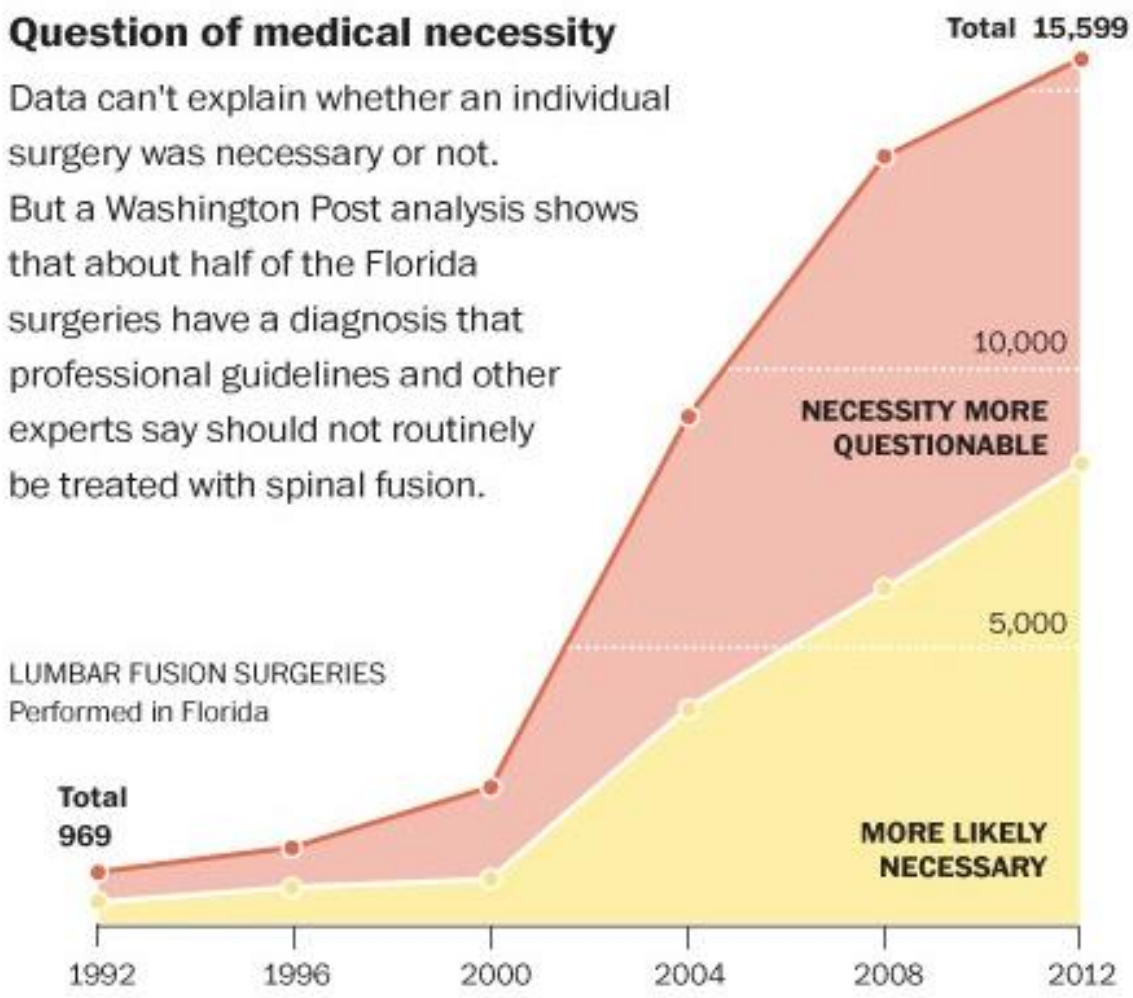
Washington Post 10/27/2013



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Spine SCOAP Outcomes after Spine Surgery

- N=1965 spine surgery candidates with baseline and at least one follow up interview; 80.6% with elective fusion
- Overall 306/528 (58%) improved in Oswestry by at least 15/100 points at 12 months among those with moderate/severe symptoms
- Odds of functional improvement if:
  - Workers comp 0.20 p<.001
  - Current smoker 0.43 p<.01
- Odds of NRS back pain improvement if:
  - Rx opiate use 0.65 p<.65

Khor S, et al. Development and validation of a prediction model for pain and functional outcomes after lumbar spine surgery. JAMA Surgery; March 7, 2018. doi:10.1001/jamasurg.2018.0072

URL risk calculator: https://becertain.shinyapps.io/lumbar_fusion_calculator

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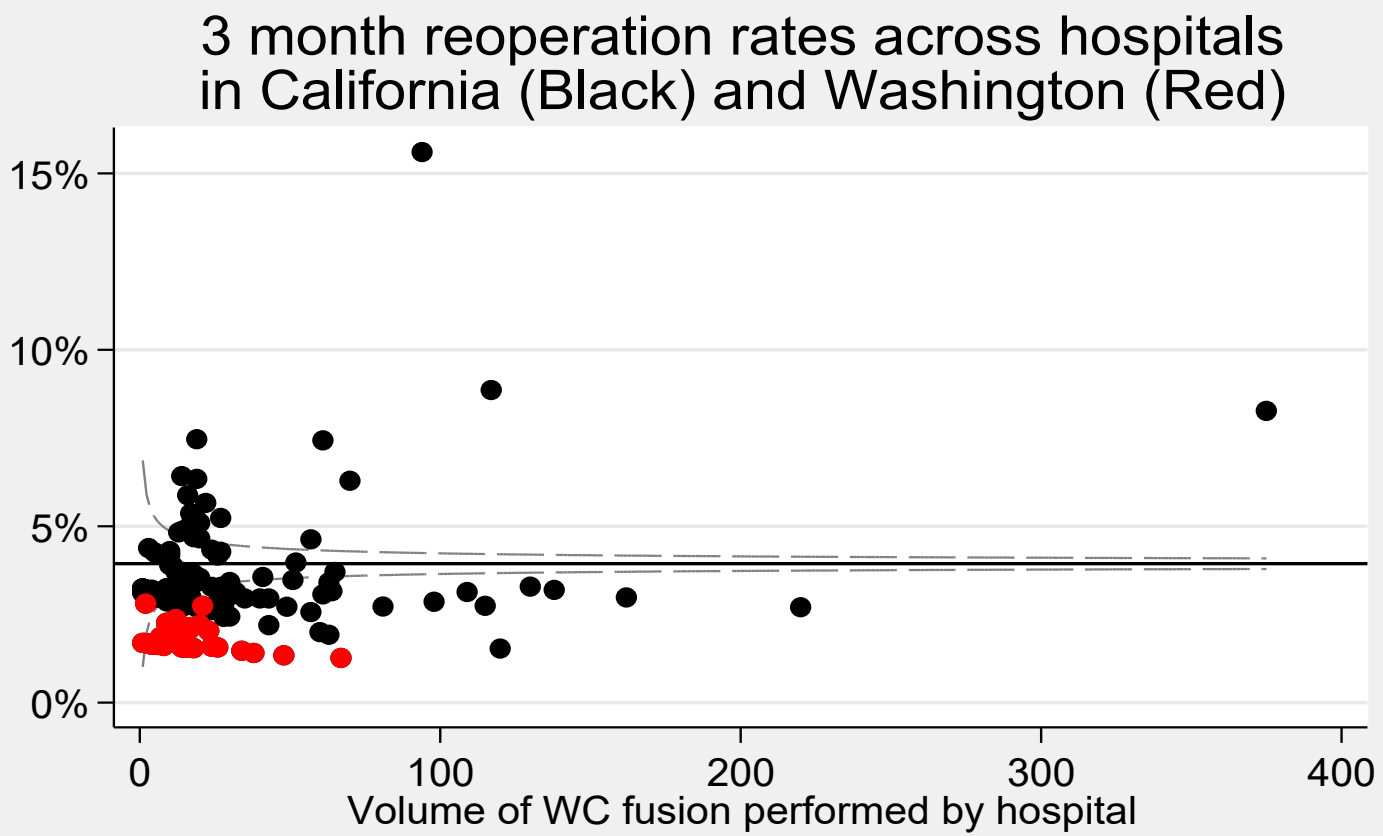

Martin BI et al, in preparation, 2012

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New Spinal Lumbar Surgery Guideline Implemented Oct 2021

- Lumbar fusion for degenerative disc disease in absence of instability or neuro impairment not covered per HTCC
- SI joint fusion not covered per HTCC
- New restrictions on repeat spinal surgery in the absence of improvement from prior surgery, and use of Gadolinium MR to better define post-op scarring
- New requirements for smoking cessation
- Stricter requirements for pre-op evaluation of patients already on opioids, eg, is there opioid dependence or OUD that needs attention
- X-ray read by radiologist required for lumbar fusion for spondylolisthesis and lumbar fusion for adjacent segment pathology.
- MRI with contrast required for repeat/revision procedures.

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Coverage Decisions in The Guideline

I. Review Criteria for Lumbar Spine Surgery

Note: Not all surgical procedures that require prior authorization appear in this criteria table.

Coverage Decisions affecting this Guideline HTCC indicates the coverage is based on a decision of the WA State Health Technology Clinical Committee.[a] Please check the HTCC webpage for the most recent information. L&I indicates the coverage is based on an L&I coverage decision.[b]	
Artificial Disc Replacement HTCC	**Not covered** for lumbar spine (Decision date March 2017).
Sacroiliac Joint Fusion, open or minimally invasive procedures HTCC	**Not covered** for adults ≥ 18 years old with chronic sacroiliac joint pain related to degenerative sacroiliitis and/or sacroiliac joint disruption (Decision date May 2019).
Lumbar Fusion for Uncomplicated Degenerative Disc Disease (UDDD) HTCC	**Not covered** for UDDD UDDD is defined as chronic low back pain of discogenic origin **without** any evidence of the following conditions: • Radiculopathy, • Functional neurologic deficits. • Spondylolisthesis (greater than grade 1). • Isthmic spondylolysis. • Primary neurogenic claudication associated with stenosis., • Fracture, tumor, infection, inflammatory disease., • Degenerative disease associated with significant deformity.
Bone Morphogenic Protein for Use in Lumbar Fusion HTCC	**Covered**: Bone morphogenetic protein-2 (rhBMP-2) for use in the lumbar spine in adults ≥ 18 years old for: Primary anterior open or laparoscopic fusion at one level between L4 and S1 **OR** Revision lumbar fusion on a compromised patient for whom autologous bone and bone marrow harvest are not feasible or not expected to result in fusion. **Not covered**: Bone morphogenetic protein-7 (rhBMP-7) for use in the lumbar spine.

[a] https://www.hca.wa.gov/about-hca/health-technology-assessment/health-technology-reviews
[b] https://lni.wa.gov/patient-care/treating-patients/conditions-and-treatments/

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Coverage Decisions in The Guideline

Single Lumbar Nerve Root Entrapment HTCC	**Covered with conditions**: Lumbar Decompression including: Lumbar laminectomy, laminotomy, discectomy, microdiscectomy, foraminotomy, far lateral decompression. **Not covered**: Minimally invasive procedures that do not include laminectomy, laminotomy, or foraminotomy including but not limited to energy ablation techniques, Automated Percutaneous Lumbar Discectomy (APLD), percutaneous laser, nucleoplasty, etc.
Discography HTCC	**Not covered**: Discography in the assessment of chronic low back pain or lumbar degenerative disc disease.
Vertebroplasty, kyphoplasty, sacroplasty HTCC	**Not covered.**
Percutaneous Discectomy, including automated percutaneous lumbar discectomy, laser discectomy, and nucleoplasty L&I	**Not covered** for disc herniation.
Staged Lumbar Fusion Procedures L&I	**Not covered**: There is no compelling surgical reason to perform a staged surgery for 1- or 2-level fusions. As such, L&I will not approve or reimburse for staged surgeries for elective procedures, unless medically necessary (e.g. complex surgery, significant spinal trauma).
Interspinous Process Devices (e.g. X-Stop, Coflex) L&I	**Not covered**: Interspinous Process Devices are not covered (2019 re-review).

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Scope of Lumbar Guideline

Fusion for:	Decompression for:
Spondylolisthesis	Disc Herniation
Prior decompression(s) at same level	Recurrent disc herniation
Pseudarthrosis, with or without hardware failure	Foraminal Stenosis
Recurrent disc herniation	Synovial Cyst
Foraminal stenosis	Nerve Root Entrapment
Adjacent Segment Pathology	Acute Cauda Equina Syndrome
	Central Spinal Stenosis

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Application of Fusion Guideline in UR Program

- Request from surgeon
- Screening nurse approves if meets guidelines
- Referred for physician review if not
- If denial recommended, offer of MD/MD contact
- Requesting physician must present clinical data that is compelling enough to overcome denial based on not meeting guideline
- Peer-matched review with spine surgeon if request stays denied after discussion

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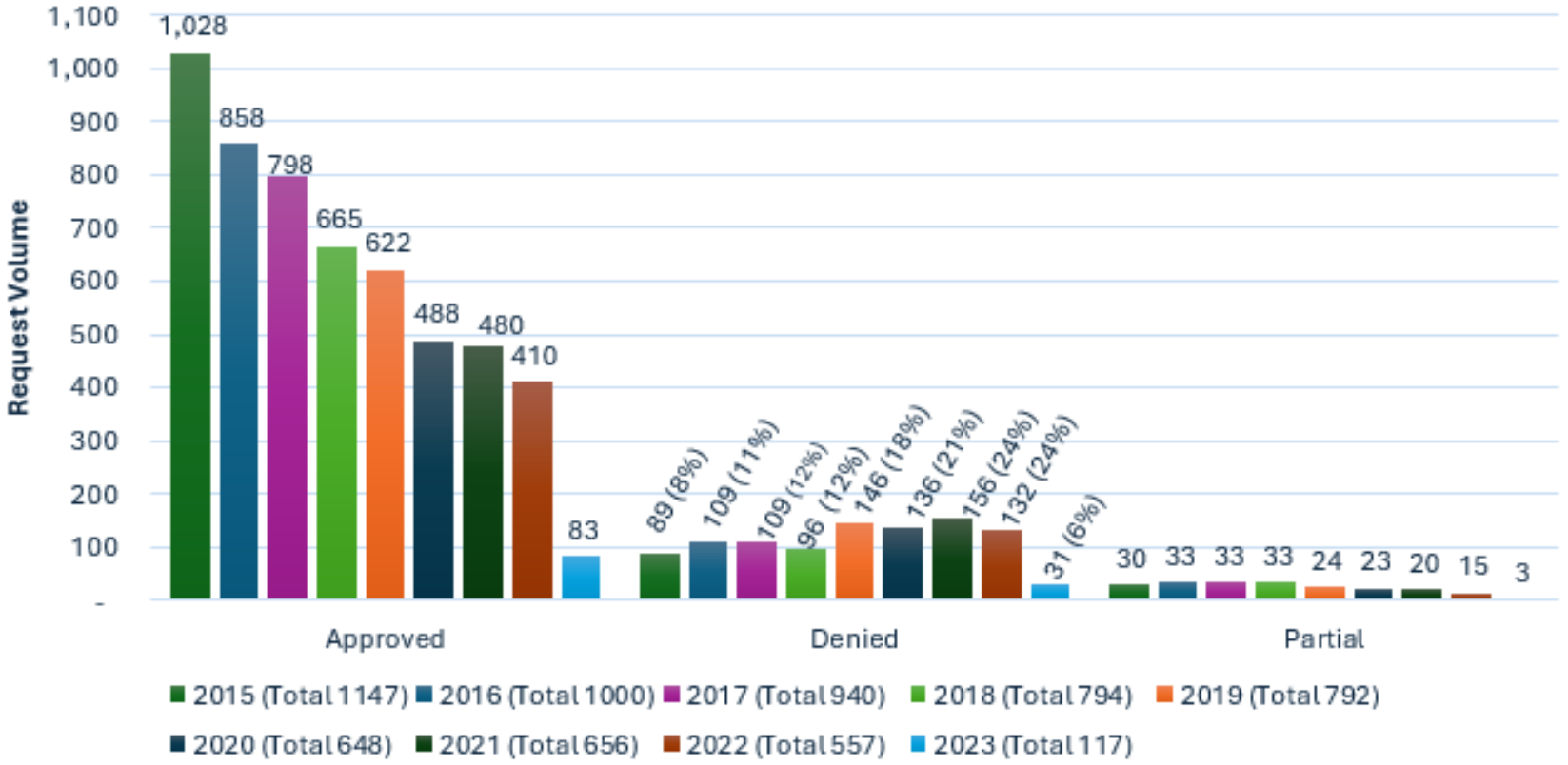
Laminectomy: Review Volumes
1/1/2015 - 3/31/2023



	Total Requests	Total Workers
2016	1,000	926
2017	940	871
2018	794	744
2019	792	733
2020	648	607
2021	656	621
2022	557	516
YTD 2023	117	115

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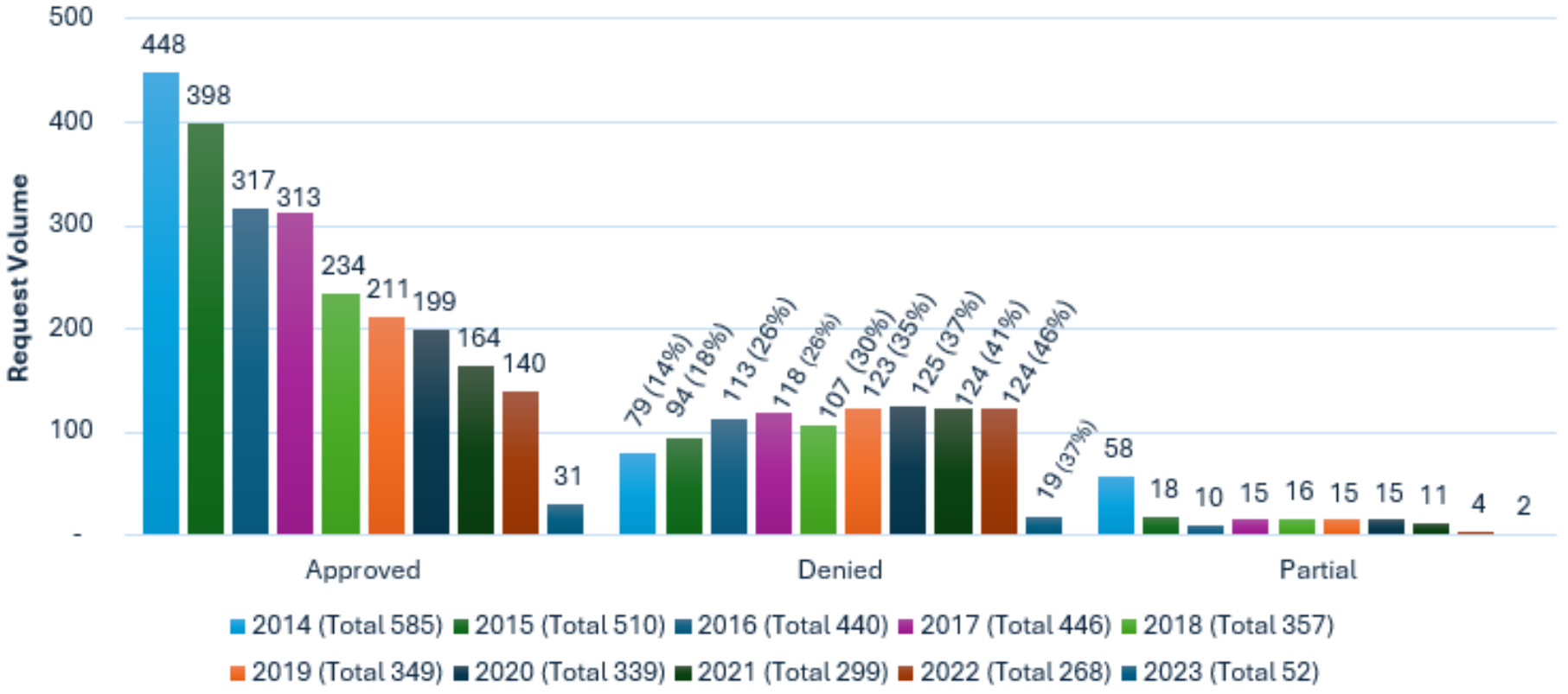
Lumbar Fusion: Review Volumes
1/1/2014 - 3/31/2023



Unique IW:

Total 2016 = 425
Total 2017 = 416
Total 2018 = 332
Total 2019 = 325
Total 2020 = 326
Total 2021 = 286
Total 2022 = 246
YTD 2023 = 50

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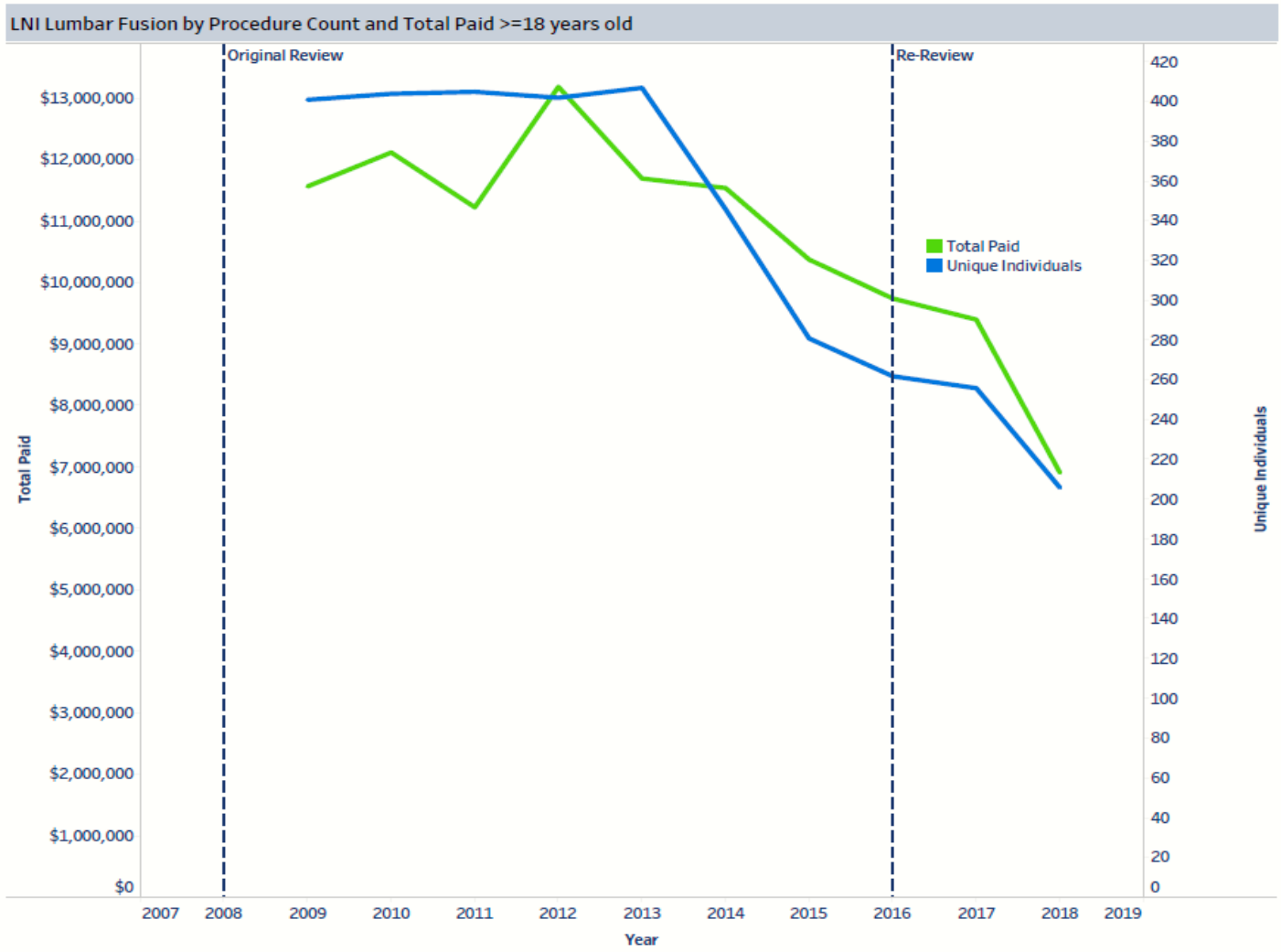
LNI - Lumbar Fusion
Determination #20151120A
Final Adoption: 1/15/2016



Number and Coverage Topic:
20151120A – Lumbar Fusion for Degenerative Disc Disease

HTCC Coverage Determination:
Lumbar fusion for degenerative disc disease uncomplicated by comorbidities is not a covered benefit.
The population addressed in this decision includes individuals > 17 years of age with chronic (3 or more months) lumbar pain and uncomplicated degenerative disc disease; excluded conditions include radiculopathy, spondylolisthesis (> Grade 1) or severe spinal stenosis, as well as acute trauma or systemic disease affecting the lumbar spine (e.g., malignancy).

HTCC Reimbursement Determination:
Limitations of Coverage: N/A

Non-Covered Indicators: N/A

Timing of In-House Review after Denial

- Regular meetings with claims consultants (MLRT) before case goes to BIIA-may lead to additional clinical data/consults/IMEs requested before final order or referral to BIIA
- Medical Director review in preparation for testimony

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Some Lumbar Fusion Arguments at BIIA

Medical Director's role and qualifications

Lumbar fusion is based on an unproven theory and decision to conduct fusion in the past based almost entirely on unreliable, subjective test (discography)

Evidence Re: efficacy in improving outcomes is lacking, adverse events are common, and workers' comp outcomes are extremely poor (peer-reviewed lit)

Denial based on lack of evidence (WAC 296-20-02704) and not meeting evidence-based/expert consensus treatment guideline developed by WAC committee

UR process is fair, 60% approved

SSB 5801-all network providers must follow our guidelines, coverage decisions, and policies

Point out frequent financial conflicts of interest via CMS Open payments (https://openpaymentsdata.cms.gov)

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Would Better Patient Education Help (e.g., Shared Decision-Making)?

There is no equipoise in the discussion between spine surgeon and patient Re the true odds of recovery and risk of adverse outcomes

Evidence-Based Advice for Individuals on Workers' Compensation Considering Lumbar Fusion for Chronic Low Back Pain

- The chance of an injured worker no longer being disabled two years after lumbar fusion is only 32%.
- More than 50% of workers who received lumbar fusion through the Washington workers' compensation program felt the operation had neither a positive nor negative impact on pain and disability.
- The overall rate of reoperation within two years for all fusions is approximately 23%.
- Smoking at the time of fusion greatly increases the risk of pseudoarthrosis.
- Pain relief, if it occurs, is not likely to be complete.
- The use of spine stabilization hardware [e.g. pedical screw instrumentation and/or fusion cages] in Washington workers nearly doubled the chances of having another surgery.

Bree Collaborative lumbar fusion warrantee bundle eliminates unnecessary surgery and even among those who meet criteria, a multidisciplinary team decides whether lumbar fusion is worth the risks (URL: http://www.breecollaborative.org/wp-content/uploads/4.Lumbar-Fusion-Bundle.pdf)

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THANK YOU!

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OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

Structured Intensive Multidisciplinary (Pain) Program Update

SI Colloquium
November 13, 2025

Jason Fodeman, MD, MBA
Jaymie Mai, PharmD

Washington State Department of Labor & Industries

Overview

- SIMP Evidence-Based Report
- Efforts to Implement the SIMP Report
- Key Informant Interviews
- Request for Information (RFI)

Jason Fodeman, MD, MBA
Jaymie Mai, PharmD
Washington State Department of Labor & Industries

Gatchel Interdisciplinary Chronic Pain Management (2014)

- Bonica created this concept to address fragmented health care system facing patients with chronic pain
- Based on the premise that the collective sum of medical, physical, and psychosocial rehabilitation is greater than those provided in isolation
- The goal is to have pain services centralized at one location and all under one roof providing comprehensive assessment and treatment for chronic pain.
- Integrating medical (physical exams, medication management), psychosocial (biopsychosocial evaluation and cognitive-behavioral treatment), and physical (manual therapies and functional restoration via guided exercise) to provide a comprehensive treatment approach to chronic pain.

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Gatchel Interdisciplinary Chronic Pain Management (2014)

- Supported by regular team meetings amongst the providers and constant communication

- According to Bob Gatchel, key principles responsible for better outcomes from interdisciplinary programs include
  - Dynamic treatment informed by the assessment and care of other providers
  - A team focus based on common goals developed in collaboration with the patient

Gatchel RJ, McGeary DD, McGeary CA, Lippe B. Interdisciplinary chronic pain management: past, present, and future. Am Psychol. 2014 Feb-Mar;69(2):119-30. doi: 10.1037/a0035514. PMID: 24547798.

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The AHRQ recently Published 2 Reports on the Treatment of Chronic Pain

- Noninvasive nonpharmacologic treatments
  - Exercise (includes Physical Therapy)
  - CBT
  - Mind-body practices (i.e yoga, tai chi)
  - MBSR
  - Massage
  - Acupuncture
  - Spinal manipulation
  - Low-level laser therapy
  - Multidisciplinary rehabilitation

Skelly AC, Chou R, Dettori JR, Turner JA, Friedly JL, Rundell SD, Fu R, Brodt ED, Wasson N, Kantner S, Ferguson AJR. Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review Update. Comparative Effectiveness Review No. 227. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No. 20-EHC009. Rockville, MD: Agency for Healthcare Research and Quality; April 2020. DOI: https://doi.org/10.23970/AHRQEPCCER227. Posted final reports are located on the Effective Health Care Program search page.

- Non-opioid pharmacologic treatments
  - NSAIDS
  - SNRIs
  - Anticonvulsants
  - Gabapentinoids

McDonagh MS, Selph SS, Buckley DI, Holmes RS, Mauer K, Ramirez S, Hsu FC, Dana T, Fu R, Chou R. Nonopioid Pharmacologic Treatments for Chronic Pain. Comparative Effectiveness Review No. 228. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No. 20-EHC010. Rockville, MD: Agency for Healthcare Research and Quality; April 2020. DOI: 10.23970/AHRQEPCCER228. Posted final reports are located on the Effective Health Care Program search page.

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Structured Intensive Multidisciplinary Program (SIMP)

- Also known as “pain clinic” or Interdisciplinary Pain Rehabilitation (IPR)
- Outpatient programs that deliver regularly scheduled, daily, interdisciplinary care for the treatment of chronic pain
- Programs are five days per week, six to eight hours days for two to four weeks in duration
- Medical services are coordinated, goal directed, and team based
    - Functional (PT/OT)
    - Patient education (pain/goals)
    - Medication management (review/optimize)
    - Cognitive-behavioral therapy (biofeedback/relaxation)
    - Vocational services
    - Psych (evaluation and treatment)
    - Weaning (opioids/benzodiazepines)

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SIMP

- 2016 – 2018: Met with SIMP providers to explore SIMP extension into communities and reducing opioid use
- 2018 – 2019: Explored and identified services that SIMP can deploy for a less intensive, multidisciplinary model to be used earlier in the claim
  - No changes to referral criteria, worker eligibility criteria, CARF requirement
  - Recommended clarification on authorization language for CMs and consideration of telemedicine policy for SIMP follow-up services
- 2020: Developed a temporary emergency policy for teleSIMP in response to COVID
- 2020 – 2021: Evaluating SIMP services in our system to better understand the current state and identify potential gaps in care for chronic pain.
- 2021 – Present: Implementing the recommendations from the SIMP Evidence-Based Report
- 2021 – Present: Thinking strategically about opportunities to enhance SIMP services for workers with chronic pain (SIMP 2.0)
- 2022 – Developed a permanent Telehealth policy and a process for exemptions
- 2023 – 2024: Conducted a Request for Information to learn more about other integrated and coordinated models, including those with differing levels of intensity, for treating chronic pain outside of our system.

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OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

SIMP Evidence-Based Report

Jason Fodeman, MD, MBA
Jaymie Mai, PharmD

Washington State Department of Labor & Industries

Project Goals

- Assess whether workers participating in SIMPs are receiving consistent services amongst various SIMP providers and that those services are consistent with the medical literature

- Assess the level of coordination between SIMPs, referring providers, attending providers, claim managers and assigned private vocational providers

- Determine whether workers who participate in SIMPs are offered appropriate and consistent follow up to transition back into their community for support and resources

- Collect and analyze SIMP data to assist with making informed decisions on recommendations for improvement

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OCCUPATIONAL HEALTH **BEST PRACTICES**

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Evidence-based Review Workgroup

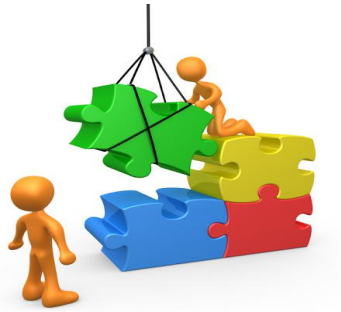

Image courtesy of clipartlibrary.com

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Jaymie Mai, PharmD

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Pain Conditions

- SIMPs have been used predominantly for the following pain conditions
  - Fibromyalgia
  - Chronic low back pain
  - Chronic non-cancer pain
    - Specified vs. unspecified various conditions
    - Fibromyalgia
    - Low back pain
    - Chronic headache
    - Lower limb pain
    - Shoulder or upper limb pain

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Demographics

- Average age of patients going to a SIMP in the studies ranged from an average of 43.52 to 52.6 years
- Average duration of pain ranged from 34.98 months to 10.83 years
- Hooten et al
  - 58.2% had pain for 5 or more years
  - 38.6% had pain for 10 or more years
  - 23.4% had pain for 15 or more years
  - 13.3% had pain for 20 or more years

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Opioid Use

- Eight of the studies reported information on opioid use at admission
  - In these studies, the percentage of patients on daily opioids ranged from 35% to 100%
  - Average MME of patients entering a SIMP were 61.2 MME (Cristosomo et al) to 47.05 MME (LD COT group) to 342.09 MME (HD COT group) in (Huffman et al)
  - Three studies reported on average duration of opioid use
    - 3.9 years
    - 4.6 years
    - 5.8 years

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Intervention

- The intervention consisted of 3 weeks, 4 weeks, or 3 to 4 weeks of intensive, daily interdisciplinary outpatient treatment
  - PT
  - OT
  - CBT
  - Patient education
  - Opioid taper
  - Medical management

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Literature Review Outcomes

- SIMPs showed statistically significant improvements in pain, function, depression and pain catastrophizing at discharge
  - Nine studies evaluated the impact on pain
  - Nine studies assessed the impact on depression
  - Eight studies evaluated function
  - Eight of the studies reported on opioid use post intervention
  - Seven of the studies tracked pain catastrophizing

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Literature Review Outcomes (cont.)

- Studies that tracked outcome measure at 6 and 12 months showed retention of benefits at 6 and 12 months, but there was a decay in improvements
  - Eight studies presented outcome measures at discharge
    - Three included 6-month follow-up
    - One included 6- and 12-month follow-up
  - Two studies presented outcomes at just 12-month follow-up

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SIMP Impact on Opioid Outcomes at Discharge and Follow Up

Study	Discharge	6-Month Follow-Up	12-Month Follow-Up
Rome et al. (2004)	97.8% completed taper		
Hooten et al. (2007)	Percent on opioids 38.4% → 2.8%		
Cristosomo et al. (2008)	Fusion: Percent on Opioids 65.2% → 18% Non-Fusion Spine Surgery: Percent on Opioids 70% → 5% No Spine Surgery: Percent on Opioids 48.4% → 10.5%		
Townsend et al. (2008)	92.6% completed taper	86.1% not on opioids	
Huffman et al. (2013)	100% completed taper		77.5% not on opioids
Cunningham et al. (2016)	100% weaned off		
Huffman et al. (2017)	86.7% COT patients tapered • LD – 85.1% • HD – 88.9%	78.8% not on COT • LD – 71.4% • HD – 68.9%	Opioid use – 75.4% not on COT • LD – 64.7% • HD – 64.7%
Gilliam et al. (2018)	100% completed taper	89.9% not on opioids	

SIMPReviewReport041621.pdf (wa.gov)

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Data Analysis Workgroup

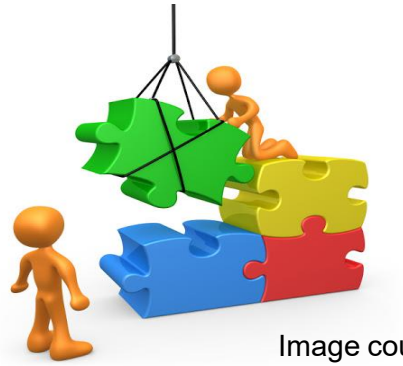

Image courtesy of clipartlibrary.com

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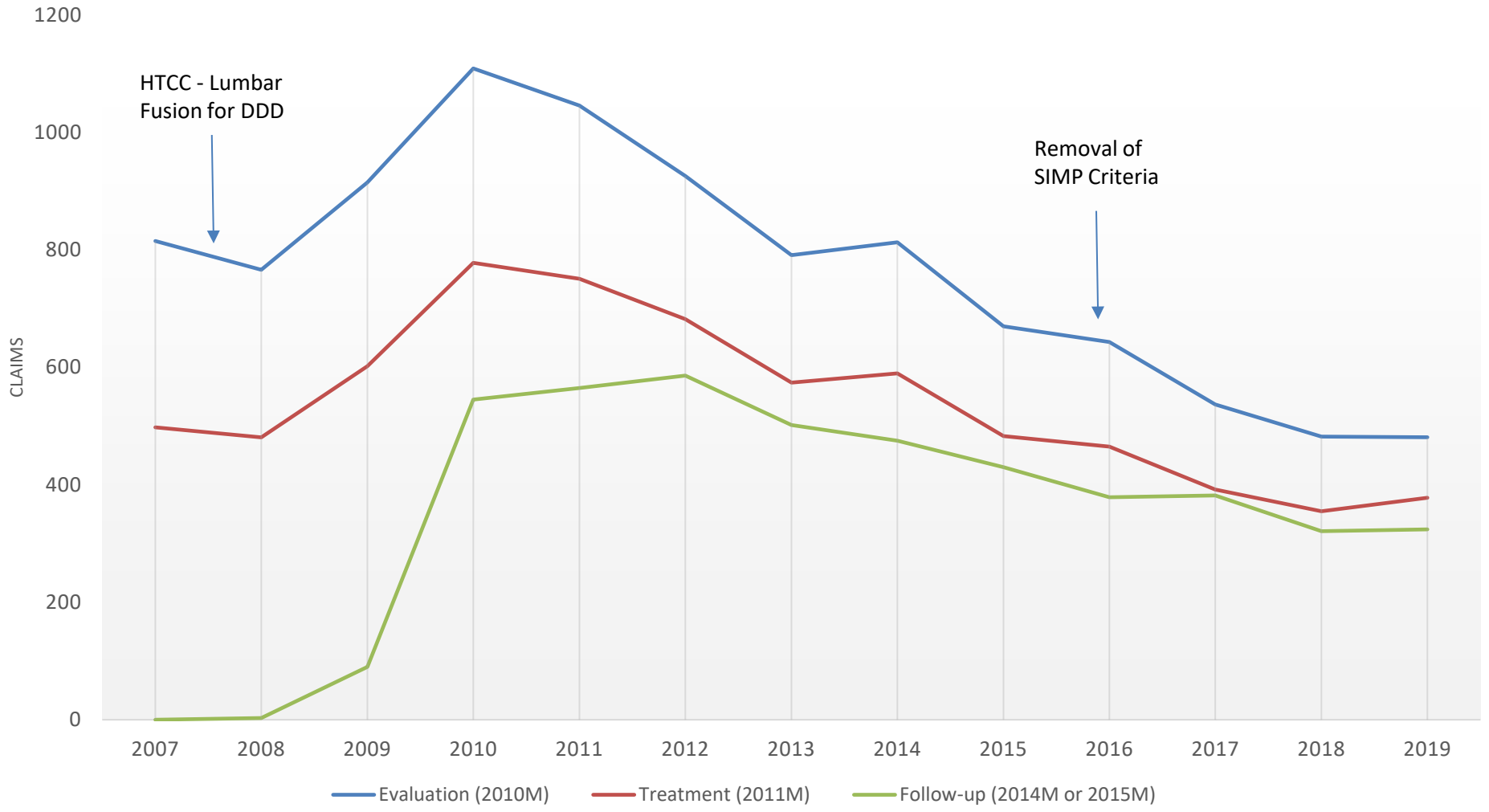
SIMP Services - State Fund



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Method of Claim Sampling

- Sampled 10% of 1,084 claims with SIMP treatment billed between 2017 and 2019
  - Sample claims were proportional to treatment provided each year by individual SIMP providers

- Identified over 100 elements for data collection

- Claims QA collected claim-related data elements while several ONCs collected clinical-related elements

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Demographics

Table 1: Worker Characteristics	
	Claim Sample (N=108)
Mean age	46 years
Claim age at evaluation	
Median	22 months
Range	3 months - 12 years
Language	
English	49 (45%)
Spanish	53 (49%)
Other	6 (6%)
Legal representation	52 (48%)
Reason for SIMP referral	
Chronic pain	108 (100%)
Unable to work due to pain	99 (92%)
Chronic opioid use	19 (18%)
Work status at evaluation	
Working	8 (7%)
Not working	100 (93%)

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Evaluate and Track Outcomes

Table 3: Use of Validated Tools for Assessment	
	Claim Sample (N=108)
Evaluation	
Catastrophizing (PCS, TSK,FAS)	60 (56%)
Pain (NRS, VAS, BPI)	104 (96%)
Pain Inteference (PEG, 2-item, PROMIS)	21 (19%)
Mental Health (PHQ, GAD-7, HAM-D, BDI, DASS 21, BAI)	72 (67%)
Disability (ODI, WHODAS 2.0)	71 (66%)
Treatment discharge	
Pain (NRS, VAS, BPI)	86 (80%)

PCS – Pain Catastrophizing Scale, TSK – Tampa Scale of Kinesiophobia, FAS – Fear Avoidance Scale, NRS – Numerical Rating Scale, VAS – Visual Analog Scale, BPI – Brief Pain Inventory, PEG – Pain, Enjoyment of life and General activity, 2-item – 2-item Graded Chronic Pain Scale, PROMIS – Patient Reported Outcomes Measurement Information System, PHQ-9 – Patient Health Questionnaire, GAD-7 – General Anxiety Disorder, HAM-D – Hamilton Depression Rating Scale, BDI – Beck Depression Inventory, DASS 21 – Depression Anxiety and Stress Scale, BAI – Beck Anxiety Inventory, ODI – Oswestry Disability Index, WHODAS 2.0 – World Health Organization Disability Assessment Schedule 2.0

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SIMP Service Components

Table 5A: PreSIMP or SIMP Readiness	
	Claim Sample (n=25)
Treatment components	
Physical therapy/occupational therapy	15
Medical management	4
Behavioral health (biofeedback, CBT)	4
Inpatient detoxification	1
Others (injections, imagine, preexisting conditions, etc.)	15

Table 5B: Treatment Components	
	Claim Sample (N=108)
Physical therapy/occupational therapy	108 (100%)
Medical management	101 (94%)
Behavioral health (biofeedback, CBT)	73 (68%)
Education	100 (93%)
Opioid wean	8 (7%)
Mental health	47 (44%)
Vocational services	100 (93%)

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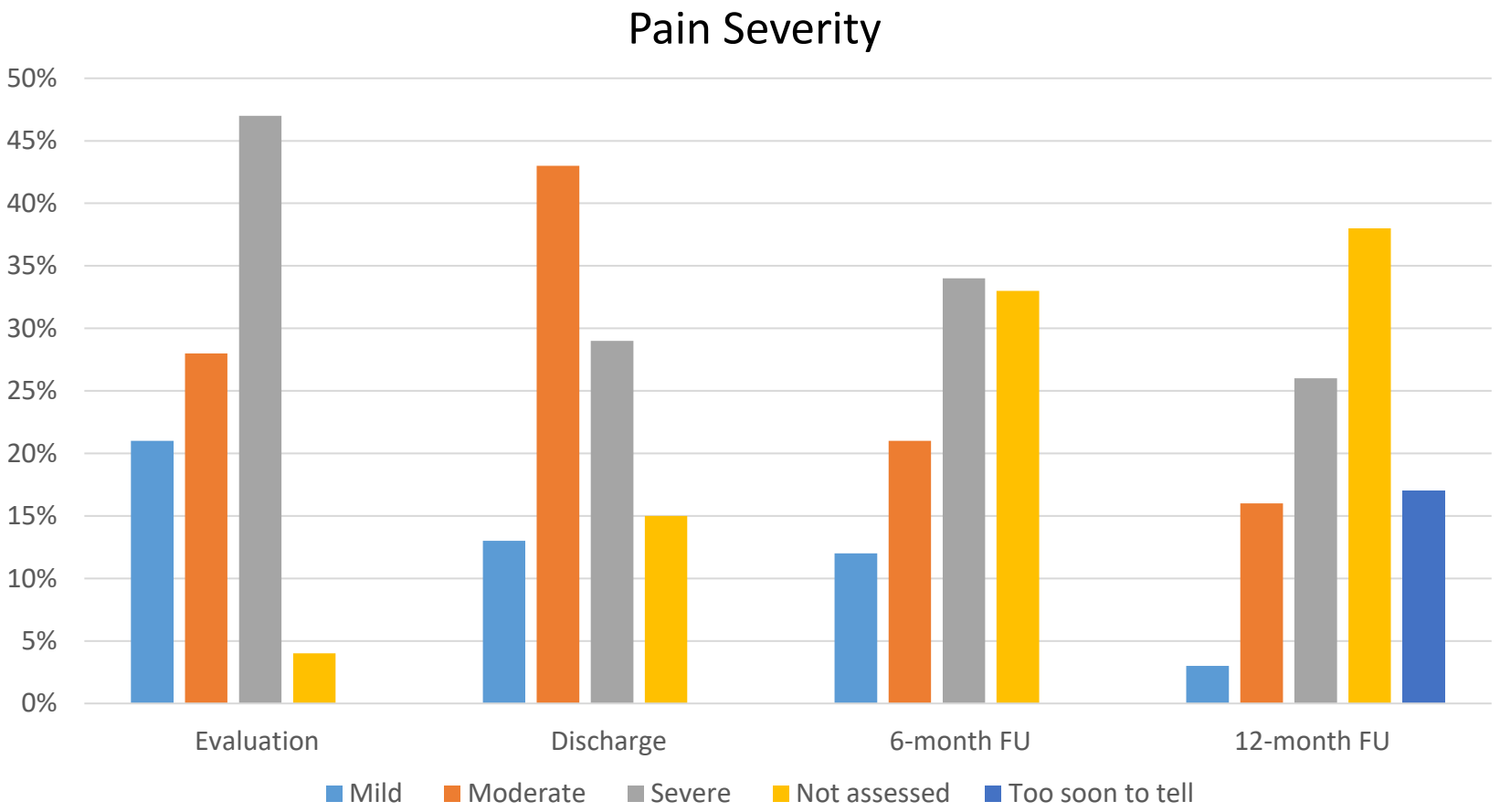
Outcomes – Pain Status



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Outcomes – Opioid Use

Table 6: Opioid Use (PMP)				
	Claim Sample (N=108)			
	Evaluation	Discharge	6-month FU	12-month FU
Chronic Opioid Dose	n=19	n=16	n=15	n=14
1 - 20 MED	3 (16%)	2 (13%)	4 (27%)	6 (43%)
20 - 50 MED	8 (42%)	6 (38%)	5 (33%)	5 (36%)
51 - 90 MED	6 (32%)	7 (44%)	5 (33%)	3 (21%)
91 - 120 MED	1 (5%)	1 (5%)	1 (7%)	0
>120 MED	1 (5%)	0	0	0

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Outcomes – Function and Mental Health

Table 7A: Function Status				
	Claim Sample (N=108)			
Pain Interference with Function	Evaluation (n=108)	Discharge (n=100)	6-month FU (n=87)	12-month FU (n=76)
Minimal	10 (9%)	7 (7%)	6 (7%)	5 (7%)
Moderate	18 (17%)	31 (31%)	17 (20%)	11 (14%)
Severe	76 (70%)	47 (47%)	19 (22%)	12 (16%)
Not assessed	4 (4%)	15 (15%)	45 (52%)	35 (46%)
Too soon to tell				13 (17%)

Table 7B: Mental Health Status				
	Claim Sample (N=108)			
	Evaluation (n=108)	Discharge (n=100)	6-month FU (n=87)	12-month FU (n=76)
Mental Health				
No diagnosis	7 (6%)	6 (6%)	3 (3%)	2 (3%)
Mild	22 (20%)	22 (22%)	7 (8%)	8 (11%)
Moderate	40 (37%)	35 (35%)	15 (17%)	4 (5%)
Severe	37 (34%)	18 (18%)	10 (11%)	9 (12%)
Not assessed	2 (3%)	19 (19%)	52 (60%)	40 (53%)
Too soon to tell				13 (17%)

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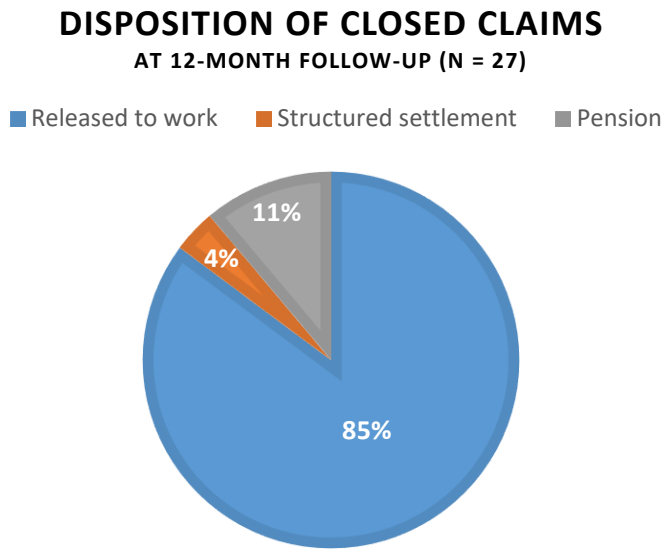
Outcomes – Claim Status

Table 7C: Claim Status				
Claim Sample (N=108)				
	Evaluation	Discharge	6-month FU	12-month FU
Closed	0	0	14	27
Open	108	108	94	68
Too soon to tell				13



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Follow-up Services

Table 8: Follow-up Services	
	Claim Sample (N=108)
Follow-up services (n=88)	
Care coordination	17 (19%)
Medical management	84 (95%)
Vocational services	67 (76%)
Care transition	23 (26%)
No documentation	4 (5%)

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Conclusions and Recommendations

- Insufficient use of validated tools to track outcomes
  - We recommend requiring validated tools (including PMP) be used at evaluation, treatment discharge and follow-up visits
- Inconsistent treatment services provided
  - We recommend applying consistent treatment components across SIMPs (e.g. behavioral health, opioid taper, mental health)
- Lack of coordination with key stakeholders
  - We recommend requiring coordination with attending provider, prescriber, CM and external vocational consultant at treatment, discharge and during follow-up visits

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Conclusions and Recommendations (cont.)

- Little to no communication to set expectation and coordinate care
  - We recommend developing standard communication for attending provider, prescriber and worker who participate in SIMP treatment
- Variability in timeliness of received reports and report content associated with treatment and follow up visits
  - We recommend applying consistent documentation and reporting requirement

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Conclusions and Recommendations (cont.)

- Inconsistent outcomes with current global reimbursement model across SIMP providers
  - We recommend L&I explore the feasibility of value-based payments to drive improvements in workers' outcomes
- Lack of clarity of Commission on Accreditation of Rehabilitation Facilities (CARF) requirement
  - We recommend reiterating CARF requirement
- Lack of clarity on the right timing for SIMP treatment and best ways to transition patients back to their community
  - We recommend additional evidence-based review and research in these areas to help guide enhancement

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Efforts to Implement the SIMP Report Recommendations

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Implementation of Report Recommendations

Recommendation	Implementation of Recommendation
Validated tools	We have made changes in MARFS to incorporate this recommendation into policy • Checking the Prescription Drug Monitoring Program Database during the Evaluation Phase and the SIMP Treatment Phase • Using consistent valid tests and instruments to track an individual worker's Pain and Function across the SIMP continuum
Consistent Services	We have been conducting outreach to SIMP Providers to promote consistent services at the SIMP
Coordination with Key Stakeholders	We have made changes in MARFS to incorporate this recommendation into policy • The SIMP physician calling the attending provider to discuss the workers treatment in the program, progress, barriers, and discharge plan at time of SIMP Discharge

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Implementation of Report Recommendations

Recommendation	Implementation of Recommendation
Communication to Set Expectations	Developed educational materials and educational tools to promote a common understanding of SIMP and improve adjudication of SIMP claims • Resources for Claims • Training for Claims Manager (2023, 2025) and Occupational Nurse Consultant (2022) Developed external communication to provide education and promote a common understanding on SIMP. We are currently creating SIMP letters to AP and IW.
Timeliness of received reports	We have made changes in MARFS to incorporate this recommendation into policy. • Providing the insurer with the required documentation in a timely manner

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Implementation of Report Recommendations

Recommendation	Implementation of Recommendation
Value – Based Payment	
CARF	Worked to clarify the CARF requirement and reiterate its importance. Worked with staff to develop a process to promote high-quality treatment and ensure the Department receives the information it needs.
Additional Evidence – Based Review and research	Conducted Key Informant Interviews. Completed a Request For Information to learn more about integrated and coordinated treatment programs for chronic pain outside our system

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Key Informant Interviews – Other Chronic Pain Programs

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CBI Health (Canada)

- Several programs with varying intensity:
- Interdisciplinary Outpatient Rehab Program: up to 2 hours per day and up to 3 days per week. In most instances, treatment is up to 8 weeks.
- Pain Management program: The program is multi hours per day (minimum of 3.5 hours) and provided multiple days per week typically lasts a maximum of 8-10 weeks. Attendance frequently is 3-5 days per week front-end loaded with a taper.
- Pain and Medication Management Program: Several hours per day (minimum of 3.5 hours) and multiple days per week and is typically completed in 8-10 weeks. Attendance is usually 3-5 days per week, more frequent at the beginning of a program with a taper
- Pain and Medication Management Program: This program is several hours per day (a minimum of 4 hours each day) and is provided multiple days per week (3-5 days per week) with a typical program duration of 8-12 weeks; the specific program length is a function of the taper plan duration. Attendance frequently is 3-5 days per week with individual appointments each week with program physician, pharmacist, and psychologist.
- Unique – Utilize Key Performance Indicators with Value-Based Payment

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Multidisciplinary Pain Clinic - North Florida/South Georgia Veterans Health System

- Multidisciplinary primary care pain clinic established to manage veterans at high-risk for non-cancer chronic pain and addiction: high-dose opioid therapy > 100 MME, hx of opioid addiction; addiction to opioids combined with benzodiazepines; and patients with comorbid medical issues (e.g., sleep apnea)
- It is structured with 1-hour first visits, and 30-minute follow-up visits to allow enough time for comprehensive evaluation while meeting the needs for close follow-up support.
- Staffed by primary care physicians trained in IM and FM. All physicians in the clinic have buprenorphine prescribing credentials to aid in the management of opioid addiction. The multimodal care model consists of addiction psychiatrists, interventional pain specialists, pain psychologists, and pain pharmacologists who coordinate the care to the veterans.
- Treatment component – Patient education, social work, mental health, medication injections, acupuncture, mobility, CBT, mindfulness
- As opioids are tapered, the clinic reinforces improved pain care through a multimodal biopsychosocial model and a self- management approach
- There is ongoing collaboration to develop the best care plan that meets the patient's needs for chronic pain, addiction, and/or mental health issues.
- Unique – Addressing addiction and incorporation of addiction psychiatrists that provide treatment as well as academic detailing/support to the primary care physician.

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Chief Judge Robert F. Arrigan Rehabilitation Center (Rhode Island)

- Nonprofit outpatient rehabilitation facility operated by the Department of Labor & Training (RI WC)
- Multidisciplinary team – PT, OT, nurses, physician, psychologist, vocational, MT, peer leaders, and Reike
- Services – PT, OT, aquatic, work hardening, medical management, psychological counseling, support group, educational workshop, vocational services, job placement assistance, and retraining programs
- Start out with massage and Reike to facilitate relaxation
- Employ nurse case managers who follow the worker in the program and coordinate with referring provider, insurer, employer about RTW options
- Closely aligned with workers' compensation court and court can refer workers to program
- Not CARF accredited
- Unique – Addressing social determinants of health

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Transdisciplinary Care at SAVAS Health (Riverside, CA)

- Complex Medicaid patient most of which are on opioids (approximately 80 – 90%)
- Inclusion criteria: Chronic pain and at least 2 of (Opioid dose >90 MME, condition refractory to usual treatment, multiple medical comorbidity, comorbid mental health or SUD, Social Determinants of health affecting health, medical costs consistent with high utilizer status or “rising risk” status
- Multidisciplinary team – Doctors, addiction specialists, interventional specialists, NP, PA, psychologist, social workers, cognitive behavioral specialist, PT, MT, fitness instructors, yoga, tai chi, acupuncturists, dieticians, nutritional therapists
- They also utilize a nurse care coordinator
- Longer period of time (1 year). With variable intensity such as weekly or once every other week. Typically starts out intensive at beginning (weekly) and then transition to less frequently. Program divided into 4 three month cycles. Reassessment happens after each cycle. Cycle broken down into 3 four – week period. Each period is broken down into 1.5 – 2.5 hour units
- Typically 8 patients in a unit
- Unique – Program is longitudinal

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PRIDE (Productive Rehabilitation Institute of Dallas for Ergonomics) (Dallas)

- A medically directed, interdisciplinary functional restoration program and chronic pain management facility accredited by CARF
- The core treatment components - medical management, PT, OT, weaning opioids, pain management education, psychological counseling, biofeedback, and case management
- Treatment plan is highly individualized and foundational principle is building trust with the patient
- Program is 160 hours and delivered in different ways to meet the needs of the patient
- Offers a daily model but also a 2-3 full day program over 8-12 weeks. The majority of patient participate in the 2 - 3 full day program
- The Interdisciplinary team consists of physician, nurse, PT, OT, psychologist, case manager, biofeedback specialist, and the patient
- Physician on site and accessible to clinical team
- Unique – Flexible model

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Request for Information (RFI)

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Request for Information (RFI)

- Conducted a Request for Information (RFI) on integrated and coordinated treatment programs for chronic non-cancer pain to supplement prior SIMP efforts and to learn more about these programs outside of L&I system.

- The RFI entitled Interdisciplinary Pain Rehabilitation Program (SIMP) was issued on May 10, 2024 and closed on September 9, 2024.

- Approximately 50 stakeholders were notified of the solicitation, targeting current SIMP providers along with leaders in chronic pain and worker's compensation.

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RFI Results

- Department received 4 responses to the RFI
  - 1 provider outside the L&I system
  - 2 current SIMP providers
  - 1 potential program under development

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Key Takeaways from RFI

- Responses to the questions varied significantly.
- Program outside of the L&I system appears to have more flexibility in intensity, frequency and duration.
- Programs vary in the area of medical involvement particularly with respect to assessment of comorbidity, medication evaluation, medication modification, and opioid weaning with a goal of zero.

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Key Takeaways from RFI (cont.)

- Other areas of variation across the responses included:
  - Involvement of the family both in the evaluation for candidacy as well as during the treatment phase of the program.
  - Assessment and monitoring of patient's willingness and motivation to participate in the program.
  - Weaning of opioids and the weaning other sedative medications
  - Amount of coordination and communication amongst team members (Daily rounds versus weekly team conference)
  - The frequency of monitoring goals, reevaluating goals, assessing for poor responders, and addressing identified issues.
  - The individualization of the components based on workers needs.
  - Coordination and communication with external stakeholders

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Key Takeaways from RFI (cont.)

- Other areas of variation across the responses included:
  - Key Performance Indicators (process versus outcome measure)

- A few unique features about the program outside of L&I:
  - Allows graduates of the program to return to the program at any time to participate in group activities
  - Payer mix consisting of workers' compensation as well as commercial insurance and self-insured employers

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Next Steps

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Next Steps

- Exploring the feasibility of a modified model for SIMP and early identification of claims for treatment:
  - L&I's current SIMP model is an intensive model. It may not address workers with less intensive needs
  - Additional model that is less intensive to allow more flexibility to meet workers' needs and could be deployed earlier in the claim
  - Provide multidisciplinary chronic pain treatment in any phase of the claim

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Resources

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For more information see SIMP coverage decision and MARFS CH 34 Chronic Pain Management

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10 Minute Break

Reminder: Stay logged in at the end of the Colloquium for a brief presentation on how to earn CE's.

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Stump the Docs

Gary Franklin
Azadeh Farokhi
Deborah Havens
Stephanie Scheurich

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Stump the Docs

Moderator

- Stephanie Scheurich, Self-Insurance Program Manager

Doctors

- Gary Franklin, Medical Director
- Azadeh Farokhi, Associate Medical Director
- Deborah Havens, Associate Medical Director

Discussion Topics

Occupational Disease, Causation, and Chemically Related Illness

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Closing Remarks & Takeaways

Kris Tefft

Washington State Department of
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Thank you!

Optional guidance on earning continuing education credits to follow directly

Stephanie Scheurich

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Continuing Education Credit Information

Course Title: Self-Insurance Colloquium 2025

1. This course has been pre-approved by L&I's Self-Insurance Continue Education Curriculum Advisory Committee to provide continuing education credit for completion of the identified course.
   - The course is approved for **3.0** CE contact hour(s).
   - Course ID number: **004-1125-0385**
   - Course Approval Number: **WA2025-474**

2. This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CDMS® board-certified disability management specialists.
   - The course is approved for **3.0** CE contact hour(s).
   - Activity code: **S00001535**
   - Approval Number: **250000345**

Please note:

- **Attendees must complete the Post Event Evaluation/Survey to receive a Certificate of Completion.**
- Post Event Evaluations/Surveys will be sent tomorrow via your registration email.
- **The Evaluation/Survey must be completed by December 12, 2025.**
- Certificates of Completion will be emailed after the Post Event Evaluation/Survey window closes.

Questions: SIColloquium@LNI.WA.GOV

Attendance will be verified by Zoom registrant generated reports.

James Simonowski
Suzyn Daniel
Washington State Department of Labor & Industries