IME Business and Labor Advisory Team Meeting
April 05, 2022
9:30 AM – Noon (Zoom)

Present: Kelli Fussell, Kristen Baldwin-Boe, Tanya Weber, Karen Jost, Teri Baughman, Nancy Adams, Stuart Bammert, LaNea Lien, Dane Henager, Melissa Dunbar, Ann Silvernale, Richard Clyne, Chantelle Yeager, Kathy Potvin, Lloyd Brooks, Dianne Whitten, Donna Egeland

Guests: Kristin McCoy, Cristy Zarate, Bob Mayer, Sean Holloman, Carolyn Logue, Nicole Mitchell, Aimee Borrego, Tracy Fochtman, Randall Franke, Irene Suver

Absent: Cheri Ward, Gary Kolonja, Knowrasa Patrick, Kelli Zimmerman, Lisa Vivian

Brief Summary of Activities:

- Announcements & Safety Message
- IME Rules - Status
- IME Program Updates
- Old Business
- Quality Measures
- December 2020 IME Legislative Workgroup
- Updates
- Open Discussion: Concerns, Future Topics, Round the Table, Public Comments

Announcements & Safety Message:

Kristen reviewed Zoom meeting etiquette. There is time allowed at the end of the meeting for any public/guest comments. Dr. McCullough left agency in January. The Office of the Medical Director will be recruiting for that position. Debra Hatzalexiou is out so Nancy will give an update on the new rules. The guest presenters were announced.

The safety topic is Springtime tips for pet owners. Many people do home and yard improvements this time of year. Be aware of chemicals on floors and in the yard. Pets can get products on their paws and ingest them when licking their paws. Be mindful of sharp objects left out in yards that pets can step on. Easter is coming up and many flowers used in bouquets are toxic if eaten by pets.

IME Rules – Status:

Nancy gave a brief update on the new rules. The new rules were filed on March 23, 2022. They were published by the Code Reviser on April 6 and will be effective on April 23, 2022.

IME Program Updates

Interpreter Services Program – Cristy Zarate

Cristy shared stats on interpreter scheduling from April 12, 2021 through February 28, 2022. The booked appointments are counted when an interpreter accepts the appointment, even if it is given back. The success rate is accounting for completed assignments, minus the interpreter no shows and provider cancelations. The unfulfilled rate is affected primarily by interpreter no shows. The vendor is working on reducing this rate by educating interpreters on how they are impacting providers, their responsibility when accepting a referral, and making sure to cancel as soon as they know they cannot show. For about 80% of assignments canceled by the interpreter, other interpreters are able to pick up the referrals.

Process revisions were made specifically for IME. These include immediate email notice when there is no approved interpreter in the language requested, an email if the referral is unfilled two

weeks prior to the appointment, and on-demand interpreters can be used in certain circumstances. ASL/touch interpretation is not available through interpretingWorks. The lookup tool online should be used for ASL interpretation.

The contact information was shared for interpretingWorks, CTS, and Cristy.

The Department is aware the ASL look up tool needs to be updated as there are agencies still listed. Staff are working on updating website. There are still approved agencies that can be used. If they are strictly providing ASL, they can still provide services. If they provide both spoken interpretation and ASL they are not an approved L&I provider.

Telemed/ Worker Accommodation Rule-Writing Status – Kristen
Kristen announced that the IME telemedicine rule development has been delayed due to multiple priorities and current staffing shortages. We have existing temporary policies that allow telemedicine IMEs in certain circumstances.

Old Business

MPN Peer Review Process: Teri Baughman
Teri Baughman is the supervisor of the nurse unit which includes the IME Occupational Nurse Consultant (ONC) and Medical Provider Network (MPN) ONCs. Teri described the MPN provider requirements and the quality and compliance review process for these providers.

There are over 30,000 providers participating in the MPN. Almost 19,000 are delegated providers, which means they are employed by large healthcare systems that credential their own providers. The MPN serves over 76,000 locations. The WACS used in credentialing the MPN providers are WAC 296-20-01030 – Minimum Standards, and WAC 296-20-01050 – Other Standards. The most common issues they see are DOH action, loss of DEA, HCA action, and internal issues with the Department.

The Provider Accounts and Credentialing (PAC) unit credentials the MPN providers. They get 100-200 applications per month are they are processing them in about 60 days. They do this while answering all credentialing questions in about two business days.

Teri shared a chart on how the ONCs get complaints, and the potential outcomes. Complaints can come in via external customers, shared complaints from DOH, Opioid death review, and interagency sharing. They also receive internal complaints. A nurse reviews every complaint received.

The unit conducts around 50 quality of care reviews a month. The questions asked when looking at a referral are to define who, what, when, and why, and start with the basic claim information. They look to see if there is a pattern of complaints or prior similar issues, and the severity of the issues. All concerns are researched by pulling various reports such as prescribing and billing reports when necessary. They review the pertinent claims, the information the nurse collects is then sent to the Associate Medical Director (AMD) who does an initial review and decides the next steps.

The ONCs do not do outreach to the providers. Sometimes a letter is sent with Dr. Franke or Franklin's signature, or the AMD will sometimes contact providers. The department pharmacists or field nurses may also contact a provider to discuss concerns. Some cases are referred to the

Medical Commission at DOH. Once that is done, DOH handles the review. Not all concerns result in action. The process must abide by the relevant WACs. Provider education and outreach has been a helpful tool to attempt to resolve issues. This is done on a case-by-case basis and the potential issues most commonly involve claims management or opiate prescribing.

The Credentialing Committee meetings are held on average every two months, when there are providers to review. The typical meeting has three to five providers to review and the panel of medical staff matches the specialty/license type of the providers being reviewed. All pertinent documents are reviewed, including the documents reviewed by the nurses, chart reviews, prescribing reports, etc. The committee gives a recommendation, which must cite the appropriate WACs. Dr. Franklin receives the recommendation and makes the final decision. If the provider reviewed is new to the MPN, the recommendation is either to approve or deny. If they are a current provider in the MPN, the recommendation would either be no change in status or to terminate their approval.

If the provider is denied or termed they can ask for reconsideration. They need to send in new information or information pertinent to the review. The Credentialing Committee then reviews the reconsideration documents and same process is followed. This process can take months to go through before a decision is made.

Since the beginning of network in 2013, 59 providers have been denied, 50 have been termed, and 107 have withdrawn. Providers that withdraw are eligible to reapply after 5 years with certain exceptions. They will have to go through the credentialing process again. A provider can also go to the Board of Industrial Insurance Appeals (BIIA) to appeal a decision. Once the BIIA makes its decision, the Department must abide by it.

This topic on the MPN complaints and Credentialing Committee process was much appreciatedby the committee members.

Timely paperwork is something the ONCs get complaints on. They look at what has been done about this to date such as any outreach or CM contact. These types of complaints are a good time to get field ONC involved when appropriate. The CMs can refer to the field nurses directly as well. They do not need to come through the ONCs in PQC. The goal is to help providers improve and be aware of any problems.

The State Fund CMs may be very aware of the process for submitting complaints, however on the Self-Insured (SI) side they may not be as aware. A majority of the complaints do come from the State Fund side. The department has worked the last few years to help grow the relationship on the SI side, and self-insured employers and TPAs do reach out when they have questions.

The complaint email box is providercomplaint@lni.wa.gov

Self-Insurance Data – Nicole Mitchell

Nicole shared a presentation that was prepared at beginning of the year regarding what data is available for SI claims from EDI. They are collecting data directly from SI medical bills and the information shared in this meeting focuses on IME billing. They only have what is reported on the SI side and do not have all the same data as State Fund since L&I is not paying the medical bills.

Nicole shared a graph showing EDI participation from 2017 when reporting was voluntary, through

the end of 2021. The assumption is that for every claim there is at least one medical bill. Reporting became mandatory at the beginning of 2020. The historical data was not required to be submitted, only claims with injury dates as of 2020. Participation has remained steady. There was a slight dip at end of 2021 however, the data was taken in November 2021 since there is a lag in the time between the Date of Injury (DOI) and the bill being processed and reported.

Approximately 77% of SI employers reported data, 15% did not, and 8% had no claims. The SI data does not include IME referral information since it is only capturing medical bills, so the date of injury (DOI) is used to compare the data to State Fund information. Nicole shared some comparative IME data for SI and State Fund Claims. The data compared include the number of IMEs per claim since the DOI. For the SI data one IME might generate multiple bills so the only bills counted were ones that contain the local codes 1108m, 1109m or 1118m. These codes indicate an IME actually took place. Data was shared comparing SI and State Fund percentages of claims with IMEs since the DOI. The SI data was only pulled for claims that had billing data.

It was suggested that the Department compare the difference between SI and State Fund time between IMEs with Return To Work and Maximum Medical Improvement data. These conversations are just getting started now that the data is able to be looked at and compared.

Other information can be gathered for SI IMEs as well, such as amounts billed, and codes billed. There is some information that may not be available from EDI. The provider data as written on bill may not include the specific examiner(s), only who the billing group is.

Looking at the EDI participation graph, participation seemed to go down a bit after reporting was made mandatory. Outreach has not been conducted yet to the employers that are not participating. The Department is looking at participation metrics internally and determining thresholds of participation data that can be shown to employers when reaching out.
The data is only as good as what is received. When counting the employers that are participating, employers that reported at least once, however they may not have then reported data again. The employers counted as not reporting could be ones that are registered to report but there are technical issues when it comes to reporting.

In Self-Insurance they are focused on all of the data, not just employers that reported data over one that have not. They are working on putting together a plan to do more education for all employers on reporting and consistency. Lloyd said that the SI community could help with participation and getting the message out. They have a goal of self-managing within the community.

The question was asked, how many claims are represented from the 53 employers that did not report?

Quality Measures

Telemedicine IMEs – Review – Tanya
Tanya gave a brief update on her telemedicine review. From March 30, 2020 through December 31, 2021 she reviewed 269 unique claims. Her review is done using the report checklist for telemedicine. The rules that are currently on hold will determine the next steps on providing information to firms and examiners based on these reviews.

There were 769 regular report reviews for State Fund IMEs in 2021.There have been 188 State

Fund report reviews done in 2022, through February 28. There have been 29 new examiner reviews, 46 recertifying reviews, 53 10% sample reviews, and 60 telehealth reviews. There have been no focused reviews in 2022.

The delay in rule making does not affect these reviews. She is watching what comes out of the steering committee to adjust what is being looked at in the reviews. The temporary payment policy is still in place for telemedicine until the new rule is in place. The rule will probably closely match the temporary policy that's already in place. Due to conflicting priorities, staffing and resource shortages, and other new IME rules, the telemedicine rules have put this on hold.

A member said that it would be nice to try to look beyond perceived barriers to see what IMEs could become and improvements that could be made.

A member voiced an observation that no medical providers or IME firms are part of the B&L committee. Kelli said we have other forums including the IME Roundtable meeting dedicated to meeting with the IME provider community as well as IICAC, IIMAC, and Achiev meetings. This may be a good time to take a look at the Business and Labor charter to review the purpose for the group and membership.

December 2020 IME Legislative Workgroup

IME Fee Schedule Review – Bob Mayer and Sean Holloman

Bob gave a brief update regarding the fee schedule updates. Notable changes to the IME fee schedule include condensing the fee schedule by combining some ancillary billing codes into existing base codes, and increasing the base code fees because of combining these codes. For the July 2022 update, the base IME billing codes will also get a 4% Cost of Living Adjustment (COLA), and the other IME codes will get a 3% COLA. The next steps will be to make the code updates in the payment system, and make sure the descriptions are up to date. The fee schedule will be published by June 1 with a July 1 effective date.

HPPM initially did a set of interviews with IME providers and firms. The fee updates were presented to the IME community in March. The updates are based on national numbers and costs for regular office visits and overall the rates are increasing.

Bilingual Examiners Discussion – Kelli Fussell

One initiative that came out of the 6440 legislative report was that the department should consider increasing our pool of bilingual examiners and research the barriers to their recruitment. Interpreters are required to attend medical appointments where it is determined that interpretation services are necessary, per WAC 296-23-362(3). Language fluency is self-reported by the examiners on their application. The number of current self-reported bilingual examiners was shared.

The group felt that possibly from the worker's perspective it might be good to have bilingual examiners for mental health exams. It can be hard to discuss some very personal issues with a new examiner let alone with an interpreter in the room. This seems like there would have to be more of a discussion especially with examiners and firms. An interpreter is currently required in a medical exam when the worker isn't fluent in English. The interpreters must be certified and pass a test. Would bilingual examiners be required to pass a fluency test?

Especially in mental health, cultural awareness and bilingual ability can add complexity. There is a

limited pool of examiners willing to do IMEs, bilingual examiners could possibly be considered a rare specialty. The committee agreed that more thought would need to go into this since existing rules impact more than IMEs.

Updates

Claims – Nancy
Nancy gave a quick claims update. There have been lots of changes with the new WACs. They are working on updating materials and preparing training for staff on these new rules.

Scheduling – Stuart
Stuart gave a brief update on scheduling trends. The number of IME referrals prior to Covid was about 1800 per month. Through the pandemic the number of referrals dropped to about 1400-1500 referrals. With the legislative updates at the beginning of 2021, the number of referrals dropped to about 1200 a month. Fewer claims were filed in 2020 as well. This did increase in the summer of 2021. The number of claims increased about 36% during summer of 2021, to about 90% of the normal average.

Self-Insurance – LaNae
There are no updates.

Open Discussion:
The future of IMEs was a continued topic from the December meeting. There is still a perception that IME examiners do not carry as much weight as a worker's attending provider opinion. Claim Managers now have less access to IMEs as a claim resolution tool. What other tools are available when the Claim Manager needs to move the claim forward? This would be a good discussion for next meeting. Staff can look at what tools Claim Managers are given and the different training. Nancy can work with Claims training to gather information to bring back to the group.

The group would like to review the charter and mission statement for this committee. They would like to look at outcomes and improvements we are looking for. One of the new members shared that It's helpful to know what you are working towards when you are in a workgroup.

Kelli Fussell is retiring at the end of April so this is her last meeting with the group.

Future Meetings:

Thursday	**August 11, 2022**	**9:30am – 11:30**	**Location TBD**
Tuesday	**December 06, 2022**	**9:30am – 11:30**	**Location TBD**
Tuesday	**April 04, 2023**	**9:30am – 11:30**	**Location TBD**