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QUARTERLY NEWSLETTER • SUMMER 2005

Trends in Delivery of OEM Services from a Large Group Perspective

BY WILLIAM R. LEWIS, MD, VP
MEDICAL OPERATIONS, CONCENTRA
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What is on the horizon, from a large group perspective, in terms of trends that will modify or further

change OEM service offerings? First let's start with a snapshot of what a large group practice is and does. Then a blueprint for ACOEM and WOEMA can be discussed with suggestions for a role and strategy definition targeted for this segment of its constituency and these trends.

Concentra as the Example of a Large Group Practice

In terms of large group practices, Concentra is the largest with 261 clinics nationally and captures a total of 8.35% of injuries nationally based on BLS injury rates. US Healthworks (USHW) has 115 regional clinics and sees approximately 3.4% of all injuries. Finally, Occupational Health & Rehabilitation, Inc. (OH&R) is the smallest of the larger group practices with 35 regional clinics and 1% market share. Larger Hospital-based

The Board of Directors of the Western Occupational and Environmental Medical Association (WOEMA) met for a weekend retreat in January 2005 to discuss important events and trends currently facing the industry. Presentations from this gathering will be reproduced in upcoming issues of the WOEMA Quarterly Newsletter. In this cover article, William R. Lewis, MD, VP Medical Operations, Concentra Medical Centers, Phoenix, AZ shares his insights about current and coming trends in 2005.

So what services do national groups provide? Concentra nationwide sees 2,500 to 3,000 injuries every day.

systems in the West include Sharp/Mission, Kaiser and Banner. They are strong local forces but not truly regional. Based on a combined total market penetration of 13%, the perception, therefore, that large group practices are taking over the occupational system is not true.

So what services do national groups provide? As one example, Concentra nationwide sees 2,500 to 3,000 injuries every day. An accurate number of employees within the

workforce would help quantify the percentage of total occupational services these groups provide. Currently national injury care numbers are the best surrogate, but do not necessarily reflect full occupational services. A new role for large group practices with the overall occupational medicine community is as benchmark entities. The industry is looking at large groups as a point of reference for determining a baseline for care and for comparative standards and outcomes.

The primary service offerings of this group include health services, care management and network services. Health services include the treatment of work-related injuries and illnesses, physical therapy, pre-placement physicals, drug and alcohol testing, consulting and "onsites." Care management offerings involve professional services aimed at reviewing and resolving outstanding extended cases and include field and telephonic case management, IMEs, and utilization review. Network services consist of intermediary review of medical bills received for insurers and payers as well as savings to clients achieved through fee negotiation, bill review re-pricing and access to PPO networks.

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President's Message



The spotlight has increasingly been on occupational medicine during the last year, particularly in California. ACOEM's Occupational Medicine Practice Guidelines were accepted as the standard of care by the California Commission on Health and Safety and Workers Compensation (a.k.a. CHWSC, pronounced 'cheese.wick' for non-Californians

who may have heard and wondered about the meaning of this acronym). Initially adopted as an Emergency Regulation in June 2004, the rules have recently been made permanent. Parallel changes are underway in Hawaii, another WOEMA State.

California has adopted the American Medical Association Guides to the Evaluation of Permanent Impairment as the empirical standard for determining permanent disability, effective January 2005. As part of the comprehensive workers' compensation reform bill SB899, California has also developed regulations establishing medical provider networks, which will allow employers to direct employees to networks that include occupational medicine providers for the life of the claim rather than just thirty days. Studies have shown that when care is provided by occupational physicians, medical costs are reduced, with benefit to both employers and their employees.

Through its Legislative Affairs Committee and lobbyist, WOEMA (in conjunction with ACOEM) has been able to influence these legislative developments in California, and is in a position to do so in other western states when opportunities arise in the future. Doing so requires financial resources. Contributions averaging \$150 per person have been made by members of your WOEMA Board and by WOEMA members who responded to our appeal for funds earlier this year, to whom we are indebted. Over \$3,000 was raised in this way. However, this is a small percentage of the budgeted cost for this initiative, \$25,000 in 2005. I would therefore encourage you to consider making a contribution to the WOEMA legislative initiative if you have not already done so.

Please attend our annual business meeting at 12 noon on September 16, 2005 in Monterey and take part in the membership meeting. If you are unable to attend, please direct your comments and feedback to me at rorford@mayo.edu. We need your participation and support!

Robert R. Orford, MD, FACOEM
WOEMA President

Notice of Annual Business Meeting

The WOEMA Nominating Committee, chaired by Susan Tierman, MD, has submitted the following slate of nominees to the Secretary for the September 2005 election. The slate will be put before the members for approval at the Annual Business Meeting to be held on Friday, September 16, 2005 at 12 noon during the Western Occupational Health Conference at the Monterey Plaza Hotel in Monterey, California. Contested positions will be decided by mail vote after the business meeting.

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The following will continue as Directors:

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(term expires 2006)

Roger M. Belcourt, MD, MPH
(term expires 2007)

Get Ready for WOHC 2005!

BY WALTER S. NEWMAN, JR, M.D.

MEDICAL DIRECTOR, MONTEREY MUSHROOMS, INC., ADJUNCT ASSOCIATE PROFESSOR OF MEDICINE,
STANFORD UNIVERSITY, CONFERENCE CHAIR, WOHC '05



WOHC '05 in Monterey, our annual get-together, promises to be one of the best ever, with great

hospitality events for fun renewal of old acquaintances. We also hope you'll make some meaningful new professional contacts which will help you in your daily career work.

Our theme this year is "**New Horizons in Occupational Medicine.**" The WOHC planning committee has been focused on inviting speakers who can provide evidence-based data that will be both interesting and useful. Remember, WOEMA is a "big-tent" organization composed of independent clinicians, corporate medical directors, consultants, HMO based clinicians, medical school faculty, and many other types of OEM Physicians. In Monterey, there will be something for everyone!

A few program updates since the last newsletter: The Awards Committee and WOEMA Board have selected **Jefferey L. Burgess, MD**, of the University of Arizona, to receive the Jean Spencer Felton Award for excellence in scientific writing. Additionally, **Douglas A. Benner MD, FACOEM** of Kaiser Permanente is the recipient of the Rutherford T. Johnstone Lectureship Award. We hope you will join us in honoring our distinguished colleagues at lunch on Friday, September 16.

Included in the registration fee

this year is a new Saturday luncheon program. Choose between "Lunch with the Professors" or the larger "California Workers' Compensation Forum." The Lunch with the Professors discussions will take place outside on the deck overlooking Monterey Bay. Each professor will host a group of nine participants around the luncheon table. The discussion will be informal but lively. Those who do not participate in Lunch with the Professors will attend our annual political forum. Here, you may discuss and learn about the new horizons of laws, economics and politics of Occupational Medicine in our region. Sign up for Lunch with the Professors or the California Workers' Compensation Forum will be on a "first-come, first-served"

basis at the WOHC registration desk in Monterey, so be sure to come early!

As we go to press, there are rooms still available at the Portola Plaza Hotel. Please call the Portola Plaza directly at 831-649-4511 to book your reservation now. And be sure to ask for our special WOHC rate of \$189 per night. Other rooms close to Cannery Row may also be available. Please call the WOEMA office at 415-927-5736 for registration or housing assistance. I look forward to greeting each of you individually at the plenary session or perhaps at the Monterey Jazz Festival or our Monterey Bay Aquarium dinner dance.

Look forward to seeing you in Monterey! ♦

Position Available

El Dorado County, WANTED: An Independent practicing doctor with a background in Minor surgery/ ER Doctor or Occupational Med GP, to share space with VERY active established Placerville Chiropractor.

We currently have contracts with County, State and Federal Agencies as well as major retail businesses. Our office provides OSHA testing in Audiometry, Spirometry, Federal drug and alcohol (DOT) consortium TPA, as well as hundreds of pre employment physicals. We need to cover the medical injuries related to work and home.

X-ray on site, ultra sound, etc. We have the office space; you share waiting room and scheduling person. This is a great opportunity for the right professional to fill an unmet local need. For further discussion call Dr. Saxton at 800-557-1545

Trends in Delivery

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In terms of mix, the workers' compensation field is 65% of Concentra's total market served based on revenues. Occupational health represents 17% of that market; group health, 11%, and auto insurance and other industries comprise 7% of the total. Switching to customers served, 52% are insurance companies, TPAs and other payers. The other 48% are employers (114,000).

New Dynamics of Managed Care

Managed care, networks and information services can be viewed as a triad that is the major driver of change. The trend towards managed care is accelerating from two fronts. Legislatively, more states have adapted or are actively looking at MCO, HCO or MPN structures along with treatment guidelines. This trend is more dominant West of the Mississippi, and California is the most recent state to adopt this strategy. Texas will probably be the next state to adopt the ACOEM guidelines, in some form, in addition to a network solution. Colorado is an example that has used its own treatment guidelines successfully for years. Oregon is an example of a MCO State.

Our counterparts on the east coast may be blindsided by the escalating penetration of managed care in occupational health as the trend moves east which is inevitable. However, all of these remedies will not be universal trends since they are being more readily adopted in states with failed or failing workers compensation systems. Even in states with functional systems, economically driven managed care and networks are proliferating to further squeeze

out any perceived excesses.

In terms of the networks everything that can be carved out will be. Procedure networks from injection, radiology and neurodiagnostic networks are gaining momentum with the carriers and payers. Provider networks include ubiquitous physical therapy (PRN & PTPN), chiropractic and more recently orthopedic panels. Credentialing is a purported benefit of these networks, but is often solely based on who will accept the discount.

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Service Uptrends

Utilization review is another increasingly important trend crossing state lines. Even in states without legislated UR, adaptation of minimal standards by insurers may actually bode well for providers by creating uniformity and feedback in a previously unregulated and chaotic process. UR should motivate doctors and nurses to use EBM and the ACOEM guidelines as a rebuttal of payor criteria for declining a request or service. Legislated UR is being seen as complimentary to other cost control initiatives.

There is also movement towards standardized product delivery and more comprehensive single vendor services. This is in addition to a desire for vertical integration. The goal is more uniformity and consistency from occupational providers. This is particularly true with regional and national employers who desire consolidation to gain efficiencies from dealing

with dozens of entities with different forms, processes and procedures. Concentra, as an example, capitalizes on this trend by having a national network even to the extent of having some loss leader clinics in California, which are necessary to complete the network based on national client needs.

Service discounting is more and more prevalent and is here to stay. State fee schedules are the most frequently requested discount. Similar to the Network situation, providers are being asked to give up anywhere from 5-40% of fees or to give up those services. Providers are caught in a vicious cycle of legislated fee schedule increases nullified by payers wanting the discount increased. Who wins? Can we as a professional organization assist in minimizing these discounts or in educating stakeholders of the falsely perceived short term benefits and long term system wide detriments? There is always the possibility of losing business in a decision to not give discounts. An intensely competitive environment between providers in some markets is a major factor giving insurance companies leverage. For that matter, it is not uncommon for the Surgery lobby to be at complete odds with the Primary Care agenda. Is there a role for ACOEM in mediating these conflicting and divisive agenda's between providers? Complicating this is the wide disparity in State fee schedule payments. Illinois, similar to other mid-east states, has built in COLA and pays 80% higher for E & M codes than California. Contrast that to Arizona who had its first increase in five years and California who has not had an increase in about ten years and to add insult to injury received a 5% decrease last year.

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Trends in Delivery

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Employer outsourcing has increased as employer-based on-site services have decreased. There is the possibility that this trend is becoming cyclical and could revert. Outsourcing is also occurring in the military. The consulting role is increasing as a corollary to outsourcing. Services are still needed and employers want to be serviced locally, but some employers are spending more money on bottled water than on occupational health and preventative services.

Customer service is a rising expectation that will be met or will force changes in the delivery models as employers become increasingly demanding. No longer are excessive wait times being tolerated as in the group health arena. Employers are negotiating penalties based not only on wait times, but secretarial and procedural errors as well. Special requests for secular needs are becoming more and more common, ranging from separate waiting rooms to booking a clinic for set periods. Volume block time requests are increasing for PE and UDS services. Flexibility and creativity will be required by OEM clinics to accommodate the increasingly strident call for service. Partnering with insurers and Third Party Administrators (TPAs) to facilitate system wide solutions is the only way for everyone to participate in a win-win scenario with all the stakeholders. Expedient referrals, approvals and payment are dependent on an integration of services that will improve customer service.

The news is not all bad for the independent entrepreneurial clinician. There is an increasing focus on sub-specialty niche clinical needs.

The general OEM practice cannot be all things to all clients. The trend towards increasingly focused differentiated services will continue. The providers need to be technologically savvy and sophisticated. These boutique

Occupational health care providers are getting penny pinched. This is a quality versus vs. cost issue and we have failed to make a good case for our value.

practices are specializing in old areas with a new high tech look and include MRO, IME, UR, Episodic Consulting, Wellness and Travel Medicine services. Some are focusing on custom services for a few select clients and/or geographical areas. This can be a highly rewarding and lucrative strategy, but has some inherent increased risks.

Sophistication and penetration of electronic and information systems are extremely variable among stakeholders. Early adaptors are pushing for connectivity and uniformity. EMR, EDS, data warehouses, e-billing and outcomes are all important components. Benefits include improved reimbursement, increased efficiencies and benchmarking for quality improvement both clinically and economically.

Converse to the previously noted uptrends, downtrends in the delivery of occupational and environmental services are occurring. These include competitive difficulties with the single and small practice environment due to managed care pressures. Industrial health services are not being funded due to budgetary

constraints. Finally, net reimbursement is decreasing due to discounts, delayed reimbursement and down-coding on delivered services.

In summary, occupational health care providers are getting penny pinched. This is a quality versus vs. cost issue and we have failed to make a good case for our value. All the issues raised boil down to cost considerations. Company and Safety directors don't see the impact as they are caught in their own internal power struggles and budget issues.

The incentive is not there. In fact, many of them are being bonused solely to decrease OSHA Recordables only creating more pressure on providers to minimize services to the point of detriment to the patient. Six figure fines have been issued in California relating to this trend. As a defense, providers need to look increasingly to outcomes to justify quality medicine. How long is case duration? What were the provider and indemnity costs of the injury? We know that a focus on quality in the long run will drive down the costs but comprehensive outcomes to validate the means is lacking.

What are the "Mega Trends"?

Managed care, networks and uniformity are of key importance. There will be more affiliations and partnerships between competitors, vendors and affiliates to fulfill service needs. Increasing comparative outcomes data are driving care and will result in network or system-wide economic credentialing. State legislatures and industry trade groups will spread this gospel nationally.

Increased comprehensive services and customer service are also

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Trends in Delivery

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important trends. Employers and patients will become increasingly active and strident in the process. Responsiveness to their needs will ultimately modify service delivery. A new definition of "one stop shop" will be developed. There will be further specialty integration, whether IC's or employed, with primary care. Boutique clinics will flourish if they can be creative. Consulting roles will increase as employers opt for episodic services versus employees.

A race for electronic efficiencies will ultimately create value for all parties. The first step is getting stakeholders connected and sharing data. The next step is utilizing outcomes to raise product and service quality. Once confronted with data, most physicians are self-correcting. If provided with the tools, change can be managed constructively.

ACOEM and WOEMA – What next?

There is a role for ACOEM and WOEMA to bring together its constituencies, educate providers and provide tools to deal with some of the trends outlined. A directory of members that shows specialization and specific expertise would be useful to create networking between its members.

The directory would assist in giving exposure to the academic world which is not adequately represented. ACOEM/WOEMA needs to decide if its role is to update physicians or provide a base, core clinical competency to perform occupational medicine or both. If there is a role for the latter more intensive 6-8 hour training modules are needed to cover specific areas encompassing

anatomy, physiology, injections, treatment etc. Since the vast majority of members are primary care converts, stratified levels of ACOEM certification should be reconsidered. The assumption that providers have a baseline knowledge set when entering the specialty is a large leap of faith for

The first step is getting stakeholders connected and sharing data. The next step is utilizing outcomes to raise product and service quality.

a national College to accept.

Creativity will need to be the byword. Didactic lectures, the medical standard, may not fit the educational process in terms of the new paradigm. ACOEM/WOEMA's new additional role

needs to be first and foremost one of facilitating understanding and appreciation of all the diversity and value of its constituents.

Secondly, a new search for more appropriate learning tools seems self-evident. Internet forums, computer workshops, group forums with projects and DVDs are all teaching tools that more reflect our new high-tech world and the content that needs to be presented. We must move away from classroom-style training if we want our constituents to grasp and implement new concepts. Interactive forums are needed. Specific intensive modules on niche product lines and clinical topics from both a clinical and implementation focus are examples.

Managed care and EBM are going to force changes that are not easily assimilated by large groups of OEM providers. ACOEM/WOEMA is the ideal vehicle to bridge the gap. ♦



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15% DISCOUNT WOEMA MEMBERS

Evaluating Medical Treatment Guideline Sets for Injured Workers in California

Prepared in November of 2004 for the Commission on Health and Safety and Workers' Compensation and the Division of Workers' Compensation, California Department of Industrial, the Rand Report was prepared as an examination of medical guidelines that might be used to evaluate the appropriateness of care provided California's injured workers, based on the requirement of California SB 228 (Alarcon) The following are highlights from the tables in the Executive Summary.

From our research conclusions and the stakeholder comments described above, we provide the following recommendations to the state for the short term, intermediate term, and long term:

Short Term (After December 1, 2004)

1. The panelists preferred the ACOEM guideline set to the alternatives, and it is already in use in the California workers' compensation system; therefore, there is no reason to switch to a different comprehensive guideline set at this time.

2. ACOEM content was rated comprehensive and valid for three of the four surgical topics considered, and our evaluation methods appeared successful for these topics; therefore, the state can confidently implement the ACOEM guideline for carpal tunnel surgery, shoulder surgery, and lumbar spinal decompression surgery.

3. Spinal fusion surgery is especially controversial, risky, and rapidly increasing in the United States (Deyo 2004, Lipson 2004),

The entire Rand Report may be downloaded from http://www.rand.org/pubs/working_papers/2004/RAND_WR203.pdf

warranting additional emphasis. The AAOS content was rated comprehensive and valid for this procedure as well as for lumbar spinal decompression surgery; therefore, the state can confidently implement the AAOS guideline for lumbar spinal fusion surgeries and, if convenient, for lumbar spinal decompression surgery.

4. The ACOEM guideline set performed well for three of the four categories of surgery we evaluated. Generalizing these findings to other surgical topics would be reasonable; therefore, the state could implement the ACOEM guideline for other surgical topics.

5. Our findings question the validity of the ACOEM guideline for the physical modalities and the remaining content, but our evaluation methods appeared to have important limitations for these areas; therefore, we are not confident that the ACOEM guideline is valid for nonsurgical topics. Deciding whether or not to continue using ACOEM for nonsurgical topics as an interim strategy remains a policy matter.

a. To identify high quality guidelines for the nonsurgical topics, we recommend that the state proceed with the intermediate-term solutions described below as quickly as possible.

6. We suggest implementing regulations to clarify the following issues:

◆ Stakeholder interviews suggest that payors in the California workers' compensation system are applying the ACOEM guidelines inconsistently and sometimes for topics the guideline does not address or addresses only minimally; therefore, we recommend that the state issue regulations clarifying the topics for which the adopted guideline should apply. 1. e.g., acupuncture, chronic conditions, and other topics our stakeholder interviews suggest may not be covered well by the ACOEM guideline.

◆ For topics the adopted guideline does not apply to, the state should clarify who bears the burden of proof for establishing appropriateness of care.

◆ For topics not covered by the adopted guideline and throughout the claims adjudication process, the state should consider testing the use of a defined hierarchy to weigh relative strengths of evidence.

◆ Because the medical literature addressing appropriateness and quantity of care may be very limited for some physical modalities and other tests and therapies, some guideline content will include a component of expert opinion; therefore, the state should clarify whether expert opinion constitutes an acceptable form of evidence within "evidence-based, peer-reviewed, nationally recognized standards of care."

◆ Our stakeholder interviews suggest that payors are uncertain whether they have the authority to approve exceptions to the guidelines for patients with unusual medical needs. Therefore, the state should

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Evaluating Guideline

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consider specifically authorizing payors to use medical judgment in deciding whether care at variance with the adopted guidelines should be allowed.

Intermediate Term

1. If the state wishes to develop a future patchwork of existing guidelines addressing work-related injuries, our research suggests the following priority topic areas: physical therapy of the spine and extremities, chiropractic manipulation of the spine and extremities, spinal and paraspinal injection procedures, magnetic resonance imaging (MRI) of the spine, chronic pain, occupational therapy, devices and new technologies, and acupuncture. When guidelines within a patchwork have overlapping content, the state may want to identify and resolve conflicting recommendations before adopting the additional guidelines.

2. Because high scores in the technical evaluation were not associated with high evaluations by expert clinicians, we recommend that future evaluations of existing medical treatment guidelines include a clinical-evaluation component. Specifically, we recommend against adopting guidelines solely on the basis of acceptance by the National Guideline Clearinghouse or a similar standard because this ensures only the technical quality of listed guidelines.

3. If the State wishes to employ the clinical evaluation method we developed for multiple future analyses, we suggest that at least one analysis should involve an attempt to confirm the validity of the clinical-evaluation method,

including determining the effect of a literature review on panel findings.

4. Lack of a comprehensive literature review appeared to be a major limitation in our evaluation of content addressing the physical modalities; therefore, future evaluations addressing the physical modalities should include a comprehensive literature review.

Longer Term

1. Our technical evaluation revealed that ACOEM and AAOS developers did a poor job of considering implementation issues, and our stakeholder interviews indicated that payors are applying the ACOEM guideline in an

When guidelines within a patchwork have overlapping content, the state may want to identify and resolve conflicting recommendations before adopting the additional guidelines.

inconsistent fashion. Therefore, we recommend that the state develop a consistent set of utilization criteria (i.e., overuse criteria) to be used by all payors.

◆ Rather than covering all aspects of care for a clinical problem, as guidelines do, these utilization criteria should be targeted to clinical circumstances relevant to determining the appropriateness of specific tests and therapies.

◆ Rather than defining appropriateness for all tests and therapies provided to injured workers, the criteria should focus on common injuries that frequently lead to costly and inappropriate services.

◆ The utilization criteria should be usable for either prospective or retrospective assessments of appropriateness, because utilization management in the California workers' compensation system involves both types of activities.

◆ The criteria should use precise language so that they will be interpreted consistently.

2. Another task within this project addresses developing a quality monitoring system for California workers' compensation. Under use of medical care is one important component of quality; therefore, the state may need to develop criteria for measuring underuse. It would be resource-efficient for the state to develop the overuse and underuse criteria at the same time.

3. There are two basic ways the state could develop overuse and underuse criteria:

◆ The criteria could be developed from existing guidelines, such as the ACOEM, AAOS, and any other guidelines judged valid in future studies. We suspect that it may be somewhat difficult to develop overuse criteria from clinical guidelines.

◆ The criteria could be developed from the literature and expert opinion, without the intermediate step of developing or selecting guidelines. ◆

This is part of the RAND Institute for Civil Justice and RAND Health working paper series. Evaluating Medical Treatment Guideline Sets for Injured Workers in California, WR 203, November 2004, pages xxiv - xxvii

Teryl K. Nuckols, Barbara O. Wynn, Yee-Wei Lim, Rebecca Shaw, Soeren Mattke, Thomas Wickizer, Philip Harber, Peggy Wallace, Steven Asch, Catherine Maclean, Rena Hasenfeld.

WOEMA Takes a Stand

Legislative Update for WOEMA Members

BY DONALD SCHINSKE, WOEMA'S LEGISLATIVE ADVOCATE AND POLICY ANALYST
ADVOCACY & MANAGEMENT GROUP, INC., SACRAMENTO, CALIFORNIA



After two years of convulsive change to California's Workers' Compensation system, the vital signs are stabilizing. In April, the Governor's pick as the Administrative Director of the Division of Workers' Compensation – whose confirmation WOEMA supported – narrowly survived a furious effort by organized labor and plaintiffs' attorneys to deny her permanent appointment. Similarly, courts have given no traction to those groups' challenges of the new conservative Permanent Disability Rating Schedule.

Meanwhile, premium rates continue to retreat. On June 1, Insurance Commissioner John Garamendi posted a target reduction rate of 18-percent for policies issued after July 1, while the State Compensation Insurance Fund announced a 14-percent rate reduction for new and renewing policies.

For the most part, the Legislature itself is letting the reforms of the past two years settle out. In late June, a bill to create rate regulation – SB 46 (Alarcón) – was killed by the Assembly after the downward trend in rates became clear. There have been other effort to tinker, and WOEMA this spring opposed two efforts that would undermine the practice of occupational medicine within Work Comp. These were:

AB 681 (Vargas) – WOEMA

WOEMA Opposes:
AB 6811 (Vargas)
AB 1256 (Koretz)
AB 1256 (Bermudez)

WOEMA Supports:
AB 805 (Chu)
AB 104 (Ortiz)

vigorously opposed this bill, which as introduced would have frozen the current physician fee schedule until 2011. WOEMA members and staff spoke to numerous legislators and their staffs about the bill, which was backed by the surgeons and other procedural specialists reimbursed relatively well under the Official Medical Fee Schedule.

Meanwhile, Dr. Peter Swann testified forcefully against it in the Assembly Insurance Committee. Dr. Swann underscored the additional workload for primary treating physicians (PTPs) under the reforms and the historic disparities in the fee scheduled, which has drastically undervalued cognitive services. WOEMA's cause was aided by labor's late opposition, and AB 681 only hobbled to its first fiscal committee where it finally stalled.

AB 1256 (Koretz) – This bill would allow acupuncturists to serve as qualified medical evaluators (QMEs) and psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractors to serve as independent medical reviewers (IMRs). The billed was pulled

from policy committee hearing and turned into a "two-year" bill, which means its progress through the two-year session was halted for this year.

WOEMA was also took positions on other bills affecting OEM physicians and their patients. Among them are:

AB 1256 (Bermudez) – This bill is a reintroduction of a proposal from last session to allow chiropractors to perform medical exams for clearance of school bus drivers. WOEMA Position: Oppose. Status: Senate Transportation hearing canceled by author.

AB 805 (Chu) – Requires Cal-OSHA Standards Board to develop standards for heat-illness prevention. Position: Support. Status: Set for Senate Appropriations committee hearing.

SB 104 (Ortiz) – Clarify authority of local law enforcement to enact orders of public health officers to prevent spread of infectious disease. Position: Support (original version). Status: Assembly Public Safety Committee.

SB 162 (Ortiz) – Would create stand alone Department of Public Health. Position: Support. Status: Two-year bill.

One clear winner this spring appears to the ACOEM Practice Guidelines. In late June, Administrative Director Andrea Hoch, whose staff has been working closely with ACOEM, issued proposed permanent regulations on

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Dr. Orford Nominated for ACOEM VP

WOEMA President Bob Orford, MD, MS, MPH, FACOEM, of Scottsdale, AZ has been nominated to run for the position of Vice President of ACOEM against challenger Jonathon Borak, MD, DABT, FACOEM of New Haven, CT.

Dr. Orford is President of WOEMA. He has previously served as President of the North Central Occupational and Environmental Medical Association and as Speaker of the ACOEM House of Delegates. He was Occupational Medicine Regent to the American College of Preventive Medicine for two terms, from 2001 – 2005, and a member of the Board of Directors of ACOEM from 1997-2000 and 2004-2007.

Board-certified in Occupational Medicine, Aerospace Medicine, General Preventive Medicine and Public Health, and in Internal Medicine, he has had over thirty years of experience in occupational medicine. Previous positions have included work in industry as a corporate medical director, in government as an agency head, in academia as a residency program director, and in clinical medicine as a program director and provider of occupational medical services.

All members of WOEMA are encouraged to support Dr. Orford in the upcoming ACOEM election, and to speak with friends and colleagues in other ACOEM components to request their support. ◆

WOEMA Launches On-Line Job Bank

The WOEMA Job Bank has recently been added to our website and was constructed to help connect our members with new employment opportunities.

Job-Seekers can post resumes anonymously online, browse job postings, create a personal “Job Alert” and manage resumes through a personalized Job Seeker Account – all at no cost for WOEMA members!

Posting job opportunities in our online Career Center is a great way to reach the ideal candidate. Several recruitment pricing options are available including a 60-day posting for only \$125. Employers and recruiters can also search our resume pool and pay only for the resumes that fit your criteria. ◆

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Legislative Review

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the use of the guidelines as the system's Medical Treatment Utilization Schedule. The regulations mark her rejection of a recommendation by the Commission on Health, Safety and Worker's Compensation to supplement ACOEM with the guidelines lines for spinal surgery from the American Academy of Orthopedic Surgeons, which proved to be too awkward a weld.

The final guidelines, which at presstime were undergoing a final two-week comment period, confirm the presumptive correctness of ACOEM, with the presumption controvertible by preponderance of scientific evidence. They provide that treatment can't be denied simply because it is not covered in ACOEM. However, treatment not addressed in ACOEM must be supported by other evidence-based, nationally recognized guidelines. And for cases where one treatment must be weighed against another, the regulations establish a hierarchy of evidence.

WOEMA will provide comment in support of the guidelines, just as we have commented this year on other pending sets of regulations covering Medical Provider Networks and Independent Medical Review. In the process, WOEMA has developed a strong link to the AD's office. Dr. Steve Schumann, chair of WOEMA Legislative Committee, testified in a regulatory hearing on the MPN regulations and has since been appointed to small advisory group to the Administrative Director.

In another WOEMA state, a partial adoption of the ACOEM guidelines remains in flux. Hawaii Governor Linda Lingle, in her efforts to overhaul that state's Work Comp system, adopted administrative rules that marry the

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first seven chapters of ACOEM with a set of commercially developed guidelines to serve as the treatment standard.

Hawaii's legislature, with a heavy labor backing, has passed legislation (SB 1808), to tie the Governor's hands. The Governor has vowed to veto the bill, which she must do mid-July. The Legislature has

threatened to override the veto.

For its part, ACOEM is objecting to the Governor's proposal and encouraging the pending override. ACOEM Executive Director Barry Eisenberg, in a June 1 letter to Senate President Robert Bunda, explained that the two sets of guidelines aren't compatible and cannot be stitched together. ♦

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Hoch Supports ACOEM Guidelines

Administrative Director Andrea Hoch, in a long-awaited move supported by insurers and employers, is adopting the American College of Occupational and Environmental Medicine's guidelines for the treatment of injured workers. The California Division of Workers' Compensation is soliciting comments on the proposed medical utilization schedule regulation through July 8.

Hoch's decision makes ACOEM presumptively correct. But it also gives carriers the flexibility to use other evidence-based guidelines, if warranted, and gives insurers another degree of marketplace certainty. It also provides injured workers access to care that actually cures and relieves, industry experts say. But expect lawyers, if they can't change it, to litigate against carriers for

simply complying with the law.

Some in the industry expected that Hoch might give in to applicants' attorneys and medical specialists, and adopt supplemental guidelines for injuries not specifically covered by ACOEM. But employers also expressed concerns that the use of ACOEM might lead to the denial of what they consider necessary treatment for their employees.

Research done by the California Workers' Compensation Institute says there is no evidence that medical treatment above and beyond what's recommended by ACOEM actually results in improvement for the injured worker.

Although the proposed medical utilization schedule does not specifically mention the use of other treatment guidelines, the regulations do say that treatment may not be

denied solely on the basis that the specific treatment is not addressed in ACOEM. In addition, physical therapy and chiropractic visits in excess of the 24-hour cap are not prohibited.

The regulations also provide for an evaluation committee made up of medial specialists in different fields to make recommendations on revising, updating, and supplementing the guidelines. Industry experts say that ACOEM may be more flexible than its critics think, actually providing room for treatments such as acupuncture. But it's expected that case law will be needed to determine if some treatments are covered. ♦

From the semimonthly publication Workers' Comp Executive, June 24, 2005.

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