Washington State Department of
Labor & Industries

Implementation of the Medical Provider Network and Expansion of the Centers for Occupational Health and Education (SSB 5801)

2013 Report to the Legislature

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Executive Summary

This is the second of five reports from the Department of Labor & Industries (L&I) on its implementation of Substitute Senate Bill 5801 (SSB 5801), an important piece of the historic workers' compensation reform legislation passed in 2011. SSB 5801 aimed to reduce disability among injured workers by improving the quality of medical care they receive by establishing a Medical Provider Network and expanding the Centers of Occupational Health and Education.

During 2013 L&I made significant progress toward that goal; the department is on track for reducing disability and related costs. The law requires L&I to report on progress by December 1, 2012, and then annually through December 1, 2016.

As required by the legislation, this report includes the following:

- Summary of actions taken during 2013
- Progress toward long-term goals
- Outcomes of key initiatives
- Access to care issues
- Results of disputes or controversies related to new provisions
- Whether changes are needed to further improve the occupational-health best practices care of injured workers.

ACTIONS TAKEN IN 2013

Launch of Medical Provider Network and expansion of the COHEs

On January 1, 2013, L&I launched a robust network for injured workers covered by L&I and self-insured employers. Workers in all parts of the state now have access to health-care providers that meet certain credentialing standards. Ninety-nine percent of injured workers statewide live within 15 miles of at least five primary-care network providers. The network also includes a broad range of medical specialists. As of October 2013, L&I had enrolled almost 18,000 providers in the network.

In July, L&I finalized new agreements with six health-care organizations to provide Centers of Occupational Health and Education (COHEs): the four existing sponsors as well as two new ones. The sponsors are now recruiting health-care providers and they expect to offer services in 38 out of 39 counties by the end of the year. The previous number of COHE providers will more than double.

This expansion is well ahead of the schedule in the legislation, which directed L&I to extend access to COHEs to at least 50 percent of injured workers by December 2013 and to all injured workers by December 2015.

Create Top Tier

The department is directed to establish a second tier within the network for providers who demonstrate occupational-health best practices. *Top Tier* providers will be eligible to receive financial and non-financial incentives, such as streamlined authorizations. In consultation with the Provider Network Advisory Group, the department has identified preliminary eligibility criteria, though a decision to postpone implementation was made due to the number of L&I program changes underway at the time, other reforms affecting health care providers, and the additional time needed to further develop data, systems support, and provider education programs.

Build the new Occupational Health Management System

In June 2013, L&I went live with the first phase of a new computer system, the Occupational Health Management System (OHMS). This new web-based system supports care coordination, tracks providers' use of occupational-health best practices, and provides feedback to doctors.

The primary users for the first phase of the new system are health-services coordinators at the COHEs. In later phases, OHMS will be expanded to other users (for example, health-care providers) and support additional L&I programs to promote occupational-health best practices.

Test emerging best practices in occupational health

L&I had pilot projects under way during 2013 to test two emerging best practices in occupational health: Activity Coaching, and Functional Recovery Interventions. Another pilot is preparing to

launch in May 2014; this is the Surgical Best Practices pilot, aimed at improving care coordination for patients who may need surgery,

Expand scope of network advisory group

To gather policy input related to SSB 5801 implementation, L&I staff meet at least quarterly with an advisory group of clinical, business, and labor representatives. The group recently changed its name from the Provider Network Advisory Group (PNAG) to the Advisory Committee on Healthcare Innovation and Evaluation (ACHIEV). As reflected in the new name, the committee will be taking on a greater role related to COHEs and occupational-health best practices, absorbing work previously done by the health care subcommittee of the Workers' Compensation Advisory Committee (WCAC). The WCAC dissolved this subcommittee in June 2013.

IS L&I REDUCING DISABILITY AND RELATED COSTS?

A key question in measuring the success of this effort is whether disability and related costs are being reduced. It is still too early for data on how the reforms have impacted disability for injured workers and related costs to the workers' compensation system. Ongoing medical care delivered only by providers meeting standards started in 2013, as did the new COHE contracts, later than the legislative analysis assumed. However, the changes may ultimately exceed the original estimate that $218 million would be saved in the first four years of implementation. Savings through June 30, 2014 are estimated to be $105 million.

A 2011 study found that injured workers treated by COHE-affiliated health-care providers are away from work for 20 percent fewer days than other injured workers.[1] COHE care also reduces disability and medical costs by $510 per claim during the first year. Because the number of injured workers treated by COHE providers is expected to double in the next year, the department also expects to meet or exceed the original fiscal note assumptions in this area.

1 Wickizer, Thomas M., PhD, MPH, "Improving Quality, Preventing Disability and Reducing Costs in Workers' Compensation Healthcare: A Population-Based Intervention Study," *Medical Care* 94, no. 12 (2011): 1105–1111.

Progress and Achievements in 2013

In 2013 L&I established the Medical Provider Network, expanded the COHEs and made significant progress on other SSB 5801 objectives.

SUMMARY OF ACTIONS TAKEN

This section of the report describes L&I's progress during 2013 in achieving key objectives of SSB 5801. The legislation directed L&I to:

- Establish standards for medical providers who treat injured workers and manage a statewide network of providers who meet these standards
- Create a *top tier* within the network and incentives for providers who demonstrate best practices
- Expand COHEs to support providers' use of best practices
- Implement automated system to track best practices, support care coordination, and give feedback to providers
- Identify and pilot emerging best practices
- Convene an advisory group of clinical, business, and labor representatives to help develop policies and give input related to these activities
- Each of these activities is described in more detail below.

PROGRESS TOWARD LONG-TERM GOALS

The department has established goals to ensure implementation of the Medical Provider Network and Expansion of the Centers for Occupational Health and Education remain on target. Those goals are:

- To establish standards for provider performance that encourage good healthcare practices
- To remove poorly performing and unqualified providers from the system
- To provide education and resources for occupational-health best practices
- To incent provider behavior towards best practices

The Medical Provider Network will help reduce disability among injured workers of self-insured employers, as well as those covered by L&I. As described below, excellent progress in each of these goal areas is being realized through this effort.

ESTABLISH STANDARDS FOR MEDICAL PROVIDERS WHO TREAT INJURED WORKERS

In 2012, the department adopted rules to establish standards and requirements for participation in the Medical Provider Network. Minimum health care provider network standards, continuing requirements, review and denial and related standards are established under WAC 296-20-01030 through 01050. In addition, criteria for determining when a provider can be removed from the network for "risk of harm" is also defined.

MANAGE THE MEDICAL PROVIDER NETWORK

The Medical Provider Network is now part of L&I's ongoing operations. Effective January 1, 2013, injured workers are required to use network health-care providers for care beyond an initial office or emergency visit when their claim is opened. Workers have the right to choose any network provider for their care. For the first visit only, they can see a provider outside the network. The network is managed by L&I and is the same network for workers covered both by L&I and by self-insured employers.

Those providers required to be in the network to deliver ongoing treatment include physicians (medical and osteopathic), chiropractors, naturopathic physicians, doctors of podiatry, advanced registered nurse practitioners, physician assistants, dentists and optometrists. L&I can pay non-network providers only for a worker's initial visit when their injury claim is filed.

In this first phase of network implementation, out-of-state providers and provider types not listed above (such as physical therapists and occupational therapists) were not required to submit their credentials in order to continue treating injured workers.

CREATE THE NETWORK

By November 2013, over 20,000 had providers applied to the network, exceeding expectations and resulting in a very robust network with good access to care and to a wide range of medical specialties. Many major group practices and clinics applied for all of their providers, including some who had not previously been treating injured workers.

Providers were allowed to continue to treat while applications pending

The volume of applications strained L&I resources for processing applications. Applications were screened to see if they met criteria for *provisional* status, allowing the provider to treat and be paid

while L&I finished verifying and reviewing their credentials. To keep L&I workload issues from disrupting care for injured workers, L&I also adopted emergency rules so that any provider who applied prior to January 1, 2013 could continue to treat while L&I reviewed their application.[1]

Table 1. Applications to the network
(through Nov. 2013)

Status of providers' applications	Number of providers
Approved	18,124
Provisional	756[a]
Nonprovisional: Applied before Jan. 1	423[b]
Nonprovisional: Applied after Jan. 1	703
TOTAL APPROVED OR PENDING DECISION	20,006

Source: L&I Project Management Office.

[a] These providers meet criteria for provisional enrollment; they can bill and be paid for ongoing care.
[b] Providers who applied prior to Jan 1 and have applications that are still pending are also allowed to be paid for ongoing care for injured workers, even though they do not meet the standards for provisional status. Nonprovisional providers who applied after Jan 1 can be paid only for initial visits.

NETWORK APPROVAL PROCESS

L&I's criteria and processes for reviewing network applications are modeled after those used by most health plans. The providers submit a Washington Practitioner Application – the same form used by most Washington payers and hospitals – plus a signed L&I Provider Network Agreement and federal tax forms. All forms and instructions are available online at **www.JoinTheNetwork.Lni.wa.gov**.

Some provider applications are flagged for further review

L&I credentialing staff verify information on the application using public databases and other sources, query the National Practitioner Data Bank, and check all information related to the provider's application and L&I file for potential quality issues. Based on standards or criteria in our rules[2], applications may be flagged for further review and scheduled to be discussed at a meeting of

[1] L&I amended WAC 296-20-01020.

[2] WAC 296-20-01030 and WAC 296-20-01050

L&I's Credentialing Committee – a panel of practicing health-care providers contracted by L&I to review providers' qualifications. The Credentialing Committee panel reviews these applications and recommends to the L&I Medical Director whether they should be approved or denied.

Providers can request reconsideration

If the L&I Medical Director decides to deny a provider's application, L&I sends a letter summarizing the issues and quality concerns that the Credentialing Committee found in the provider's file. The provider has 60 days to request reconsideration. The provider can continue to treat injured workers during that 60-day period, or longer, if they have requested reconsideration and their request is still pending. Each reconsideration request, and any supporting information submitted by the provider, goes back to the Credentialing Committee to review and then determine whether to uphold or change their original recommendation.

Denied providers can't continue to treat during appeal

The denial becomes effective 60 days from the initial notification if the provider does not request reconsideration, or later if the Credentialing Committee reviews the provider's reconsideration request and the L&I Medical Director decides to uphold L&I's original decision. At this point, L&I's action is considered final and L&I must report the action to the National Practitioner Data Bank. If the provider appeals L&I's decision to the Board of Industrial Insurance Appeals, they cannot provide ongoing care for injured workers while their appeal is pending.

Some providers are still in the review process

As of October 2013, more than 100 providers had received initial denials. However, the number of denials is still incomplete because the Credentialing Committee is still working through applications that meet criteria for clinical review. Some providers who received initial denials were later approved on reconsideration or withdrew their application rather than risk a final denial. Others providers are still in the 60-day reconsideration period, or have a reconsideration request that is still pending.

While L&I issued only 48 final denials as of October 11, 2013, this count will likely grow as the Credentialing Committee continues to review applications and reconsideration requests. The overall denial rate based on final denials/approvals is around 0.3 percent.

Table 2. Status of denied applications
(through Oct. 11, 2013)

Status	Numbers
Providers initially denied*	97
Providers approved on reconsideration	25
Denials final and implemented	48
Denials pending or in reconsideration	24

Source: L&I Provider Credentialing and Compliance

* Excludes 22 applications withdrawn during the denial process.

QUALITY OF CARE ISSUES ADDRESSED

Initial denial letters sent through October 11, 2013 mentioned an average of more than four review criteria that were the basis of the Credentialing Committee's recommendation. The review criteria have been grouped into six categories, shown in the summary table below. Many providers are counted in more than one category. (For more information, including related rules, see Appendix A.)

Table 3. Issues that caused providers to be denied network admission
(through Oct. 11, 2013)

Categories of denials	No. of providers
1. Clinical care (liability insurance and malpractice)	43
2. Compliance with clinical guidelines	48
3. Criminal misconduct, substance abuse, sexual misconduct	20
4. License issues	77
5. Misrepresentations and omissions	27
6. Payer action or loss of hospital privileges	27

Source: L&I Provider Credentialing and Compliance

All network providers' qualifications will be re-reviewed at least every three years. L&I is also establishing processes to use data to monitor quality of care issues and remove providers who present a risk of harm to injured workers.[3]

TOP TIER

SSB 5801 directs L&I to establish a second tier within the network for providers who demonstrate occupational-health best practices. *Top Tier* providers will be eligible to receive financial and non-financial incentives, such as streamlined authorizations. L&I has worked with the Provider Network Advisory Group to discuss eligibility criteria and incentives for Top Tier. The department has also held provider focus groups on Top Tier criteria and is reviewing the infrastructure needed for Top Tier.

Preliminary eligibility criteria for the Top Tier

As a result of these discussions and the direction from the Provider Network Advisory Group (PNAG), L&I is developing preliminary eligibility criteria based on the following categories:

- Minimum number of workers' compensation patients
- Qualifications in good standing
- Use of occupational-health best practices
- Some combination of:
  - Participation in a quality improvement project
  - Board certification or other higher certification
  - Use of electronic medical records
  - Complex or at-risk patients
- Core competencies related to workers' compensation and pain management

Decision to postpone launch

In the fall 2012, PNAG decided to postpone implementation of Top Tier due to the number of L&I program changes underway at the time, other reforms affecting health care providers, and the additional time needed to further develop data, systems support (such as the new Occupational health Management Computer System), and provider education programs. Next steps are for L&I staff to continue to work on criteria, incentives, and system needs, and to develop an implementation plan for feedback and discussion.

[3] Risk of harm is defined in WAC 296-20-01100.

COHE EXPANSION

The legislation directs L&I to extend access to health-care providers participating in Centers of Occupational Health and Education (COHE). The first milestone was to expand access to COHE services to 50 percent of injured workers by December 2013, and then to 100 percent of injured workers statewide by December 2015. With new COHE contracts started in 2013, expansion is well ahead of this schedule.

How the COHEs help injured workers return to work sooner

The COHE are run by health-care delivery organizations such as clinics or hospitals that help health-care providers coordinate care and use occupational-health best practices to treat injured workers. COHE participation is voluntary – network providers are not required to join COHEs, and injured workers are not required to use COHE providers. With funding from L&I, the sponsoring organizations provide:

- Health Services Coordinators
- Clinical leadership and mentoring
- Provider outreach and training in occupational-health best practices
- Community outreach to business and labor
- Support for participation in other L&I initiatives (such as pilots of emerging best practices)

COHE sponsors enroll health-care providers who are asked to use best practices with all their injured workers, and give these providers feedback on how well they are following them.

The current COHE best practices focus on the first twelve weeks post-injury, a critical period for preventing disability. Providers receive financial incentives for demonstrated use of these best practices:

- Submitting the Report of Accident to L&I within two business days
- Completing an Activity Prescription Form at the first visit, and when the patient's status changes
- Two-way communication with the patient's employer on return-to-work options
- For patients that are still off work, developing a plan to address barriers for return to their job

COHEs began as pilots in 2002. A 2011 study by the University of Washington found that workers treated by COHE-affiliated providers have 20 percent fewer time-loss days. COHE care also reduces disability and medical costs by around $510 in the first year of the claim.[4]

[4] Wickizer, "Improving Quality, Preventing Disability," 1105 (see n. 1).

Recruiting and signing COHE sponsors

To prepare for COHE expansion, L&I held public meetings in Tukwila, Tumwater, Kennewick, Spokane, Seattle, Mount Vernon, and Kelso during October and November 2012. Many health care organizations attended. On January 22, 2013, L&I issued a Request for Proposals (RFP) to potential COHE sponsors for new contracts. Business and labor representatives participated with L&I staff in developing the RFP and evaluating proposals.

Six health-care organizations were selected on April 19, 2013, including the four previous sponsors as well as two new ones. New contracts began July 1, 2013, for five sponsors, and on August 1, 2013, for the Eastern Washington COHE.

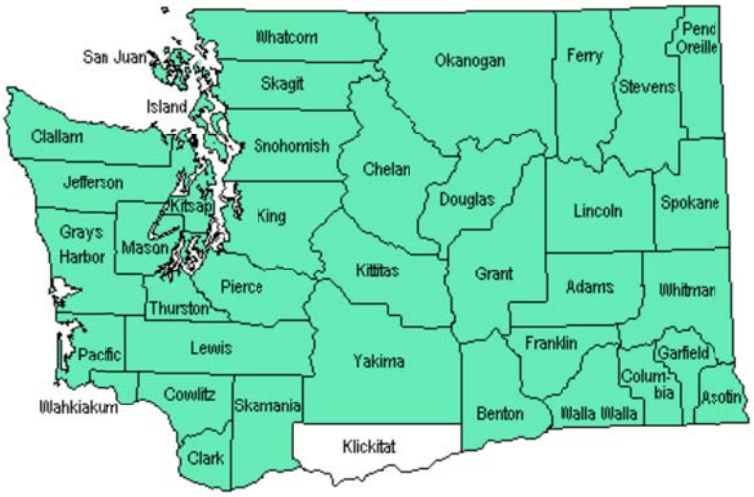
Table 4. Sponsors of Centers of Occupational Health and Education (COHEs)

Sponsoring organization	Coverage	Year sponsorship began
Valley Medical Center (the *Renton COHE*)	Enrolled community providers in parts of King and Pierce counties.	2002
St. Luke's Rehabilitation Institute/Inland Northwest Health Services (the *Eastern Washington COHE*)	Expanding from 16 to 19 counties in 2013.	2002
Harborview Medical Center	Includes providers in Harborview's trauma center and several outpatient clinics.	2007
The Everett Clinic	Includes providers in nine Snohomish County clinics operated by the Everett Clinic	2007
Franciscan Health System, lead for a coalition of 12 health care organizations	Will enroll COHE providers in all western Washington counties. Health Services Coordinators will be located in Tacoma and an office in southwest Washington.	2013
Group Health Cooperative Patients do not need to be Group Health members to see providers in these clinics for work-related injuries or illnesses.	Will provide services to injured workers at 11 Group Health clinics in western Washington and one in Spokane.	2013

Source: L&I's Occupational Health Services Unit

In addition to areas served by the two new COHE sponsors, the Eastern Washington COHE is expanding services to providers in Benton, Franklin, and Kittitas counties. The new COHE service areas cover 38 out of 39 counties. The map below shows planned coverage for COHE providers.

Figure 1. COHEs after expansion: areas served under new contracts



Next steps in COHE expansion

L&I will continue its work to bring on board the new COHE sponsors and build up services in the new counties covered. Through the fall of 2013, COHE sponsors will be recruiting providers in their service areas and training them in occupational-health best practices and other COHE processes.

Two Business and Labor Advisory Boards, one in western Washington and one in eastern Washington, are being established to gather community input on COHE expansion and operations. In 2014, a gap analysis will be conducted and a plan developed for providing ongoing access to COHE services in all parts of the state.

Number of COHE providers will nearly double

Based on providers' letters of intent and the sponsors' proposals, the number of COHE-participating providers is expected to double by next year:

Table 5. How the number of COHE providers is expected to increase

	Number of COHEs	Number of providers
September 2012	4	1,774
September 2013	6	1,884
September 2014 (projected)	6	3,684

Source: L&I's Occupational Health Services Unit

Approximately 52,000 new claims are expected to be under the care of COHE providers in FY2015 — in line with fiscal note estimates. This increase is due to expansion into previously unserved counties with large numbers of injured workers, as well as offering twice as many participating providers.

IMPLEMENT A SYSTEM TO TRACK BEST PRACTICES, SUPPORT CARE COORDINATION, AND GIVE FEEDBACK TO PROVIDERS — THE OCCUPATIONAL HEALTH MANAGEMENT SYSTEM (OHMS)

In the fall of 2012, L&I selected Consilience Software to develop a new computer system to support use of occupational-health best practices. This Occupational Health Management System (OHMS) provides a web-based case management tool. L&I will build the system in multiple phases.

In the first phases, existing care coordination processes are being centralized and streamlined across COHEs, with the key users for the first release being COHE Health Services Coordinators. This release went live as planned in June 2013 in time to begin training for new COHE sponsors and support COHE expansion. Response from Health Services Coordinators was very positive. Because OHMS integrates with L&I systems, Health Services Coordinators receive work lists and claims information that is refreshed several times a day. They can send notes to L&I through a secure electronic interface.

Upcoming OHMS releases in 2014 will add new users such as COHE providers, and increase tools to identify and coordinate care for high-risk patients. OHMS will also be developed to support Top Tier and pilot projects for emerging best practices. In Release 5 (summer 2015), OHMS will integrate with providers' Electronic Medical Records. For more information about OHMS users and the release schedule, refer to Appendix B

IDENTIFY AND PILOT EMERGING BEST PRACTICES

Current COHE best practices focus on the first 12 weeks of treatment. SSB 5801 directed L&I to develop additional best practices that span the full period of recovery for longer-term cases. In collaboration with the University of Washington, L&I has had two pilots under way to test and develop emerging best practices. A third pilot will be launched in 2014.

One pilot of activity coaching began in 2012. Activity coaching helps injured workers focus on structured activity in order to overcome fears and regain normal daily function. The program's final stages center on activities that facilitate re-integration into the workplace. Coaches are trained using the Progressive Goal Attainment Program (PGAP™). This program is a standardized, community-based intervention delivered by professionals such as occupational therapists or physical therapists. Coaches for the pilot were available in most parts of the state in 2013.

A pilot of the Functional Recovery Interventions was launched with providers in the Eastern Washington COHE in 2013. The Functional Recovery Questionnaire (FRQ) is a three-question survey administered to workers who have missed two weeks of work. It is highly predictive of long-term disability: nearly 40 percent of workers identified as positive on the FRQ are disabled one year after their injury compared to fewer than 3 percent of workers with a negative FRQ. Providers participating in the pilot are offered interventions they can use to help these patients and improve outcomes.

Work is under way to finalize the design of the Surgical Best Practices Pilot. Recruitment for providers is expected to begin soon. This pilot is planned to launch in May 2014. The Surgical Best Practices Pilot focuses on improving handoffs between surgeons and primary care healthcare providers.

CONVENE AN ADVISORY BOARD

Substitute Senate Bill 5801 directed L&I to establish an advisory group with business and labor representatives chosen by L&I's Worker's Compensation Advisory Committee (WCAC), and clinical members from the Industrial Insurance Medical Advisory Group and the Industrial Insurance Chiropractic Advisory Group.

How L&I works with the advisory group

This committee, the Provider Network Advisory Group (PNAG) has met at least quarterly since July 2011 to give policy input on standards and processes for enrolling providers in the network, *risk of harm* criteria for removing network providers, eligibility and incentives for Top Tier, and other subjects related to SSB 5801 implementation. They also receive regular updates on network enrollment status and implementation issues. Advisory committee meetings are open to the public, and all meeting materials including minutes are posted online at www.ProviderNetwork.Lni.wa.gov, under *Advisory Committee*.

L&I has also worked closely with health care provider associations and other organizations to get input on implementation of these reforms.

The work of two committees has been merged

Since 1997, the WCAC has had a Health Care Subcommittee that helped with the development of the initial COHEs and advised on issues related to COHE operations and occupational-health best practices. In June 2013, the WCAC directed L&I to merge the subcommittee's activities into PNAG's activities. The WCAC ended the subcommittee and appointed one additional business representative and one additional labor representative to PNAG. To reflect its new role, PNAG now has a new name — the Advisory Committee on Healthcare Innovation and Evaluation (ACHIEV).

OUTCOMES OF KEY INITIATIVES

Network is on track to reduce disability

It is still too early for actual data to analyze how the network has affected patient outcomes. Due to the time needed for Credentialing Committee review and the 60-day reconsideration period, most L&I actions to end a provider's ability to treat injured workers took effect in the second or third quarter of 2013. More time is needed to measure the results of transitioning care for their patients to other providers. As of September 1, 2013, around 300 providers who had been Attending Providers on injured worker claims were excluded from treating injured workers – either the provider had not completed the application process or withdrew their application at some point during L&I's review, or L&I had issued a final order to deny their application.

L&I will conduct an analysis to compare claims costs for injured workers treated by providers who were either denied admission or withdrew their applications. The data are expected to be sufficiently developed to begin this analysis in 2014. Improvement in patient outcomes could prevent high-cost disabilities and generate savings that meet or exceed the fiscal note estimates.

Injured workers covered by self-insured employers are also required to use L&I's Medical Provider Network for ongoing care. During the fall of 2012, L&I began creating electronic files of provider information for self-insured employers and their Third Party Administrators (TPAs), updated daily. In 2013, L&I worked with self-insured employers and the TPAs on implementation of network payment rules and shared templates for communicating network requirements to injured workers. The network will help improve medical care for workers of self-insured employers, generating additional savings not included in the fiscal note estimates.

ACCESS TO CARE ISSUES

Throughout network implementation L&I monitored the number of injured workers in each county who lived within 15 miles of at least 5 network primary care providers, compared to 2012 baseline. This information was used to target provider recruitment and ensure an adequate geographic distribution of providers. By September 2013, the distribution was within 2 percent of baseline in 34 out of 39 counties. The table below shows statewide access figures for injured workers covered by L&I and self-insured employers.

Table 6. Access to primary care

Percentage of injured workers with access to at least 5 primary-care providers within 15 miles

	2012 Baseline	Network (as of Oct 2013)
State Fund	99%	99%
Self-Insured	99%	99%

Source: L&I analysis using Esri Geographic Information Systems software.

L&I used a number of strategies to tell injured workers about the network and help them find a network provider. In addition to informational mailings to all workers with open claims, L&I sent letters and phoned workers who did not have a network provider. An online provider directory was enhanced to support searches by driving distance (www.FindADoc.Lni.wa.gov).

L&I hired additional customer service staff to handle increased call volume and to offer additional help to injured workers. New *care transition coordinator* positions were established in each region to ensure personal assistance for injured workers who requested help transferring to a network provider. In the first nine months of network implementation, 486 injured workers were referred to the care transition coordinators. The majority of these workers were quickly placed with a new, network provider. Overall, the customer service staff and care transition coordinators were underutilized, and referrals for assistance were much lower than expected.

RESULTS OF DISPUTES RELATED TO NEW PROVISIONS

Due to the success of network recruitment, fewer-than-expected injured workers have requested help from L&I finding a network provider or raised concerns about access to care. However, some issues regarding network eligibility were controversial and some individual providers have challenged L&I's decisions to deny their application to the network. The disputes with denied providers are currently being litigated and it is too early to report results. As of early November, the Board of Industrial Insurance Appeals has just begun to hear the denied providers' appeals and has around ten active cases pending. There have been very few new appeals filed in recent months, and a major increase in appeals is not expected at this point.

ARE ADDITIONAL CHANGES NEEDED TO FURTHER IMPROVE THE OCCUPATIONAL-HEALTH BEST PRACTICES CARE OF INJURED WORKERS?

By launching the medical provider network and establishing new COHE contracts, L&I has completed the first phase of implementing the 2011 legislation. Fully achieving the vision of the SSB 5801 will be a multi-year effort. Work planned for 2014 is outlined in the conclusion to this report.

L&I is not currently requesting additional statutory changes to assist in implementing these reforms.

Conclusion

The legislation of 2011 gave L&I the ability to establish standards for the medical providers who treat injured workers, and to expand programs that develop and incentivize occupational-health best practices.

In 2013 L&I made significant progress toward these goals. These achievements are the foundation for additional work in 2014 and beyond to reduce disability by improving medical care for injured workers.

PLANS FOR 2014

- Continue reviewing applications to the Medical Provider Network and ensure that all participating providers meet network standards.
- Continue to improve application processing and turnaround.
- Develop a plan to integrate information from self-insured employers into network oversight and increase collaboration on best practice programs.
- Establish processes to re-review network providers' qualifications at least every three years.
- Monitor quality-of-care issues and remove providers who present a risk of harm to injured workers, based on the definition in WAC 296-20-01100.
- Continue to monitor injured workers' access to care, and recruit providers in needed specialties and underserved areas.
- Analyze impacts on outcomes for injured workers and workers' compensation benefit costs.
- Support COHE expansion into new areas that they have contracted to serve, and develop a plan to address any gaps in statewide access to COHE services.
- Enhance web-based tools available in OHMS to support best practices, including tools that help new users such as health-care providers.
- Continue development of Top Tier criteria, incentives, and system needs, and create an implementation plan.
- Launch the Surgical Best Practices pilot.

NEXT REPORT

The department's next legislative report on the Medical Provider Network and COHE Expansion is due December 1, 2014.

Appendix A

L&I may deny health-care providers admission into the Medical Provider Network based on numerous issues or quality concerns that may be found in a provider's file. The department has summarized the reasons for denials into six categories.

Denial categories for L&I's Medical Provider Network

1. **Clinical Care**
   – Liability Insurance (WAC 296-20-01030(2))
   – Admitting Privileges, Malpractice Claims, Inappropriate Treatment, Unlicensed staff, Risk of Harm (WAC 296-20-01050(3)(h),(i),(l),(m) and (t))
2. **Compliance with Clinical Guidelines**
   – Dept. rules, policies, guidelines or national guidelines, inappropriate prescribing (WAC 296-20-01050(3)(j) and (r))
3. **Criminal Misconduct, Substance Abuse, Sexual Misconduct**
   – Felony, Sexual Misconduct (WAC 296-20-01030(6))
   – Substance abuse, criminal history (WAC 296-20-01050(3)(b),(n) and (s))
4. **License**
   – Active, unrestricted license and DEA registration (WAC 296-20-01030(7) and (8))
   – Pending charges, non-compliance with STID, informal actions, history of license actions (WAC 296-20-01050(3)(c),(d),(o) and (p))
5. **Misrepresentation and Omissions**
   – Application misstatement/omission (WAC 296-20-01030(5))
   – Fraud, misrepresentation, billing fraud (WAC 296-20-01050(3)(k) and (q))
6. **Payer or Institutional Privileges**
   – Admitting privileges terminated, public payer termination (WAC 296-20-01030(3) and (4))
   – Payer termination/exclusion, withdraw privileges (WAC 296-20-01050(e), (f), and (g))

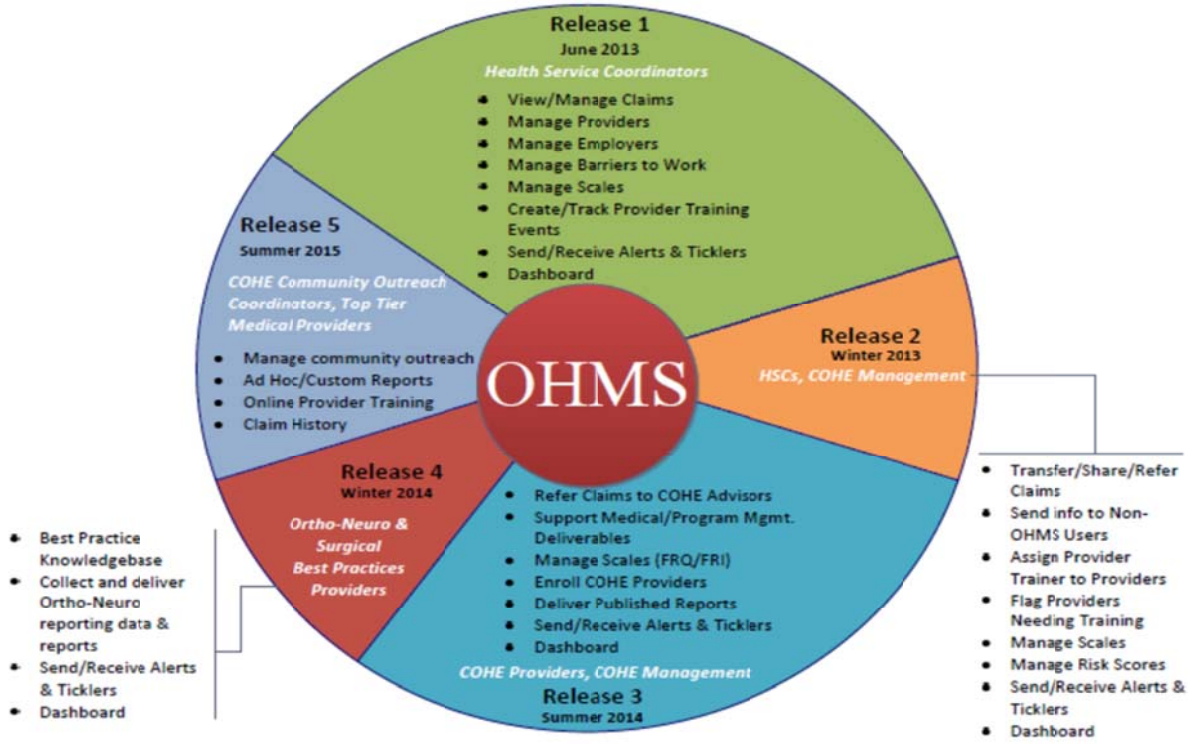
Appendix B

The Department of Labor & Industries began working with Consilience Software in 2012 to build a new computer system that will make it easier for the Centers of Occupational Health and Education to do business with us.

This Occupational Health Management System (OHMS) provides a web-based case management tool that will centralize and streamline existing care coordination processes across COHEs. It will also be used to support Top Tier and pilot projects for emerging best practices.

The first OHMS release in June 2013 was well received. The figure below summarizes future releases.

Figure 2. OHMS Users and Release Schedule



Source: L&I Information Services, Project Management Office