Washington State Department of Labor & Industries

Therapy Stakeholders Group Meeting

November 24, 2014, Tukwila Service Location, 12:30 p.m. – 3:30 p.m.

Present:

Therapy Members: Christina Casady – Capen and Associates, Josh Cobbley – Northwest Return to Work, Jackie Earl – Cascade Summit, Cheryl French Nevin – Olympic Sports and Spine Rehabilitation, Barbara Harrington – Peoples Injury Network Northwest, Terry Moon – ATI, Jim Strandy – Summit Rehabilitation, Lynda White – MVP Physical Therapy

Audience Members: Maggie Vennarucci

LNI: Karen Ahrens – Project Lead, Sarah Martin – Project Manager/Chair, Michelle Moore – Project Administrative Support

Topics

#1: PCE Clinic Approval Letter Content Review – see handout

The group supported receiving authorization and essential claim information (referral questions) via this letter. Concerns raised included getting verbal authorization but then having to wait for a letter to provide the additional content. In addition, most prefer to receive this information electronically. It was learned that most are not aware of L&I's eCorrespondence option. This would provide the letter electronically. L&I would need to do outreach to have these providers signed up. Josh's clinic is currently the only one signed up but still receiving letters via mail.

- Learned that letters sent by L&I to clinics are not seen as a timely communication method. One clinic's correspondence goes to their billing office.
- Letter allows L&I to clearly document the claim file.
- Confirmed that L&I does not fall under HIPPA requirements but we follow similar standards.

Addressing the letter content:

- Accepted Conditions – helpful
  - Denied conditions – may be helpful to know
- Referral Questions - good
- Time Limited Access - (standard 60 days) – good
- Procedure code – yes

- Date span of approval – yes
- Requirement to use standard form - ok

Additional Discussion:

- Need to be able to download any required standard form.
- Need to avoid duplication with any required forms. Minimize administrative burden. Find a way to standardize form to eliminate work duplication (i.e. work summary, JAs).
- Some APs/VRCs are relying on therapist to do the JA comparison with the capacities results so all the AP has to do is concur.
- Volume is a problem – would be okay with 5 JAs but beyond that too much. Further clarification will be needed.
- PCE for a worker with multiple claims. Can this be simplified with the PCE Provider only having to complete one set of forms/JAs?
- Discussion around JA signature page. PCE providers noted that they need to keep doing this as part of their professional review of the JA. There is a concern that if the PCE provider doesn't complete the JA signature page, the AP may not concur with the JA creating delays.
- Further discussion needed by L&I regarding what provider types are allowed to be paid to review JAs.

#2: Referral Question Feedback (for the PCE clinic approval letter) – see handout

Preliminary review of the draft referral questions.

Question asked of group: Does this cover the standard questions? Anything missing?

Q#1: Based solely on the accepted condition(s) on the claim(s):

- What are the individual's physical capacities and work tolerances?
- Can the individual perform the job(s) as described in each job description/analysis?
  - If not, identify what specific task and objective limitation this is based on for each job description/analysis.

Unclear how they are to address only accepted conditions when there are other conditions present. They would rather list the demonstrated capacities and document in the comments section what the other limiting factors were for the unrelated conditions. They can do this for each physical demand element. They need direction how to best

comment on the ability to perform the duties in a JA when there are unrelated conditions.

- Bullet #3: they are already doing this.
- Would be hard to separate out close proximity body parts to figure out what was causing limitation
- Need guidance how to address pre-post injuries
- They noted that work pattern is missing on some of their referrals.

Q#2: Identify if there are any equipment modifications that would allow for return to work accommodating a specific limitation?

Consider as an optional question.

- May be difficult for the evaluator to answer this question in all cases. Consider taking out the word equipment and rather identify examples such as shift, equipment, other.

- May not have time to fully evaluate, could give general feedback or indicate job mod assessment needed.
- If a report summary is created, consider having a standard question to include job modification. yes, no, unknown
- Can they go ahead and move forward with facilitating this consult?
- Further discussion needed to the “job modification” response.
- Need to make sure what L&I is requesting is matching what VRCs are requesting. Need uniformity.

Q#3. Do you have any additional observations or comments that came up during the test?
Q#4 Are there any unrelated issues that impacted the testing results? If yes, please explain.

Need to merge into one question. Specifically, get rid of question 3 and use Q4, consensus from group 2.

Q#5 Would additional therapy allow the worker to meet the physical demands of an identified job? If yes, what specific treatment and length are you recommending and for which job title?

Restate: group was mixed about how this question was worded and what L&I really wanted them to comment on. They suggested using the term additional rehab potential for job of injury or light duty job rather than using physical demands.

- How to address: when PCE is premature and more treatment (WC/WH) needed
- How to screen better upfront to determine if PCE may be premature to perform.
- Do you want us to comment on medically ready/stable (steroid injection)
- If yes, we want to know if this is about JOI or retraining goal but hard to address if PCE is premature (5 days post op eye surgery)
- They need to be better informed about purpose of the PCE

This would be an optional question.

Q#7. Was this a valid test of maximum capacities?

Reconsider word valid/reliability

Need to work on how to word this. For example: Do these results reflect the best abilities/capacities. Sincere effort. Using the word invalid should be avoided.

- The results would be: Best/varied/poor
- Strong effort profile

They would like direction about how to address tests where the worker shows limited effort from the beginning of the test. They would like a standardize way of what to do. Such as:

1) Not finish PCE/call CM
2) Finish but note clearly of validity concerns in a standard method.
3) Comment in a specific way –this is what worker is willing to do.

#3: Proposed Authorization Process Draft – see handout

- If attorney, need to get them on board early.
- Let them know there is a plan to have a searchable list on the L&I website to find PCE providers.
- Test to tolerance discussion:
    - Yakima area VRCs are getting the AP test for tolerance
    - They do get direct referrals from APs
    - Should test to tolerance be added to the letter?
    - Should test to tolerance term be changed to Test outside of current restrictions.
    - Are the restrictions permanent or temporary- if temporary, then they commonly will test for tolerance.
    - Should a PCE be done if there are restrictions? Some clinics test for tolerance even if not received by AP but only if IW gives consent.
    - Best practice is test to tolerance.
    - Assume test for tolerance – they send letters to doctors and if they don't hear back, it means they have the ok.
- They find it helpful to know what phase of voc the worker is in.
- Are workers entitled to lunch reimbursement?
- When there is an attorney on the claim, the therapists don't call the worker directly. They work thru the attorney.
- Attorney responsiveness is an issue causing delays
- They don't schedule if no verbal confirming appointment.
- Confirmed that IW letter going to both IW address and attorney address

#4: Timeline Expectations

Revisited and received concensus for 10 calendar days (Time from test to report in file)

What is considered report in file? Is this the summary and response to JAs or is it the full report? This will need to be addressed by L&I.

Assumptions –JAs prior to test, No more than 5 JAs to review

#5: Who is the Best Candidate for a PCE?

Best:

- Fixed/Stable
- No pending surgeries
- Appears they can they do their job but the AP is not sure
- Anytime in claim (best if less than 1 year)
- Employer has job for them (JOI/LD)
- Working modified duty (prolonged)
- No history of multiple claims
- Only claims with single claim single injury
- Medically stable
    - No further curative treatment
- Post op for condition
- Clarity of purpose for the PCE
- Benchmark for capacity – if not fully medically stable EOI requests – moving parts ie JA for light duty – JA essential, clear restrictions
- New medical condition if repeat PCE
- Worker willing to participate- motivated
- Voc at AWA or heading to training

Not Best:

- Taking Opioids
- Open wounds
- Still in therapy
- Urgent co-morbidities (MI, HBP, unstable psych)
- Structured settlement
- Pregnant – liability, must be cleared by OB
- Attorney/Interpreter
- 3rd party lawsuit
- Obvious psychosocial risk factors -Qualifies for PGAP
- Years, years, old claim
- AP placed too many restrictions
    - So many restrictions, unclear what to test
- IW says not going back to JOI/LD
- Unclear purpose of PCE = conflicting info from AP, CM and VRC
- History of Multiple PCEs
- History of low motivation/cooperation
- History of SSI/SSDI

#6: Future Name of Test (PBPCE)

- No objection of changing PB-PCE term
- PCE vs FCE
- PCE: Coding, physical demand in name, similar term to what we are using
- FCE: Functional is more descriptive to the testing they do. Other states, training programs and research use term FCE – better uniformity.

Generally, prefer the term FCE.

#7 Round Robin/Other Topics

- Like the idea of moving toward consistency and standards
- Topics they want to address next:
    - What makes a good evaluator? – assistants roles, training, benchmarks
    - Test components
    - Standard terminology – physical demand definitions, DOT is vague
    - Better evaluators, need for standardization
    - Therapist summary form

Next Meeting: January 26th