Welcome

2024 Self Insurance Colloquium Occupational Health Best Practices

November 19, 2024

8:00 AM – 12:30 PM

Technical difficulties?

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

OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

2024 Self Insurance Colloquium
Occupational Health Best Practices

November 19, 2024 Webinar

Knowrasa Patrick

Washington State Department of Labor & Industries

Mission Statement

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

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

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Safety Tip

Victoria Rich

Washington State Department of
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Safety Tip: Holiday Food Safety

The holidays are a great time for a little indulgence… Make sure you play it “food safe” whether you are preparing the big meal of just attending.

CLEAN

- Wash hands with warm water and soap for 20 seconds before and after handling any food. To help you remember, it takes about 20 seconds to sing "Happy Birthday" two times.
- Wash food-contact surfaces (cutting boards, dishes, utensils, countertops) with hot, soapy water after preparing each food item and before going on to the next item.
- Rinse fruits and vegetables thoroughly under cool running water and use a produce brush to remove surface dirt.
- Do not rinse raw meat and poultry before cooking. Washing these foods makes it more likely for bacteria to spread to areas around the sink and countertops.

COOK

- Color is not a reliable indicator of doneness. Use a food thermometer to make sure meat, poultry, and fish are cooked to a safe internal temperature.
- Bring sauces, soups, and gravies to a rolling boil when reheating.
- Cook eggs until the yolk and white are firm. When making your own eggnog or other recipe calling for raw eggs, use pasteurized shell eggs, liquid or frozen pasteurized egg products, or powdered egg whites.
- Don't eat uncooked cookie dough, which may contain raw eggs and raw flour.

Food safety tip and Be Food Safe image courtesy of FDA.gov
Turkey image courtesy of clipartbest.com

SEPARATE

- Keep raw eggs, meat, poultry, seafood, and their juices away from foods that won't be cooked. Take this precaution while shopping in the store, when storing in the refrigerator at home, and while preparing meals.
- Consider using one cutting board only for foods that will be cooked (such as raw meat, poultry, and seafood) and another one for foods that will not be cooked (such as raw fruits and vegetables).
- Keep fruits and vegetables that will be eaten raw separate from other foods such as raw meat, poultry or seafood — and from kitchen utensils used for those products.
- Do not put cooked meat or other food that is ready to eat on an unwashed plate that has held any raw eggs, meat, poultry, seafood, or their juices.

CHILL

- Refrigerate leftovers and takeout foods — and *any* type of food that should be refrigerated — within two hours. That includes pumpkin pie!
- Set your refrigerator at or below 40ºF and the freezer at 0ºF. Check both periodically with an appliance thermometer.
- Allow the correct amount of time to properly thaw food. For example, a 20-pound turkey needs four to five days to thaw completely when thawed in the refrigerator.
- Don't taste food that looks or smells questionable. A good rule to follow is, when in doubt, throw it out.
- Leftovers should be used within three to four days.

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Virtual Housekeeping

- The Q&A and Chat options can be opened using the icons at the bottom middle of your Zoom webinar window.

- The Chat option will only be available at the beginning of the event to notify us if you are having technical/audio difficulties.
  - Staff will monitor and help troubleshoot issues.

- Please use the Q&A option to ask questions.
  - Staff will monitor.
  - All questions will be either answered live, verbally or in the Q&A window, or saved for response after the event ends.
  - The question log will be made available to all attendees.

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Description of the Day's Topics

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SI Colloquium Agenda

Time	Topic
8:00 – 8:10	**Welcome and Orientation** • Safety Tip • Webinar Housekeeping Rules • Description of the Day's Topics
8:10 – 9:00	**Post Traumatic Stress Disorder Foundational Concepts**
9:00 – 9:40	**Opioid Refresher**
9:40 – 9:50	**10 Minute Break**
9:50 – 10:05	**Health Care Innovations: Physical Medicine**
10:05 – 10:20	**Health Care Innovations: Surgical Quality Care Program**
10:20 – 11:00	**Psychological vs Neuropsychological Testing**
11:00 – 11:20	**Update: Health Care Policy and Payment Methods (HPPM)** • Physician Assistants • Naturopath Payment Policy Changes
11:20 – 11:35	**Update: Psychologists as Attending Providers**
11:35 – 11:40	**Update: Medical Consultant Program**
11:40 – 11:50	**10 Minute Break**
11:50 – 12:20	**Stump the Docs** • Behavioral and Mental Health • Neurology/Neuropsychological Testing
12:20 – 12:30	**Closing Remarks and Takeaways**

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Post-Traumatic Stress Disorder
Foundational Concepts

Jennifer Jutte

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Trauma exposure in a national sample of U.S. adults (N = 2,953)

89.7%

Endorsed DSM-5 trauma exposure

Multiple events was the norm

*Kilpatrick et al., 2013

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Common Reactions to Trauma Exposure

Expected, normal reactions immediately after trauma

- **PTSD symptoms** including fear, nightmares, avoidance, etc.
  - These are common immediately after traumatic events
  - For most trauma survivors, the intensity and frequency of symptoms decrease over time without any treatment
- Guilt/shame
- Depressive symptoms

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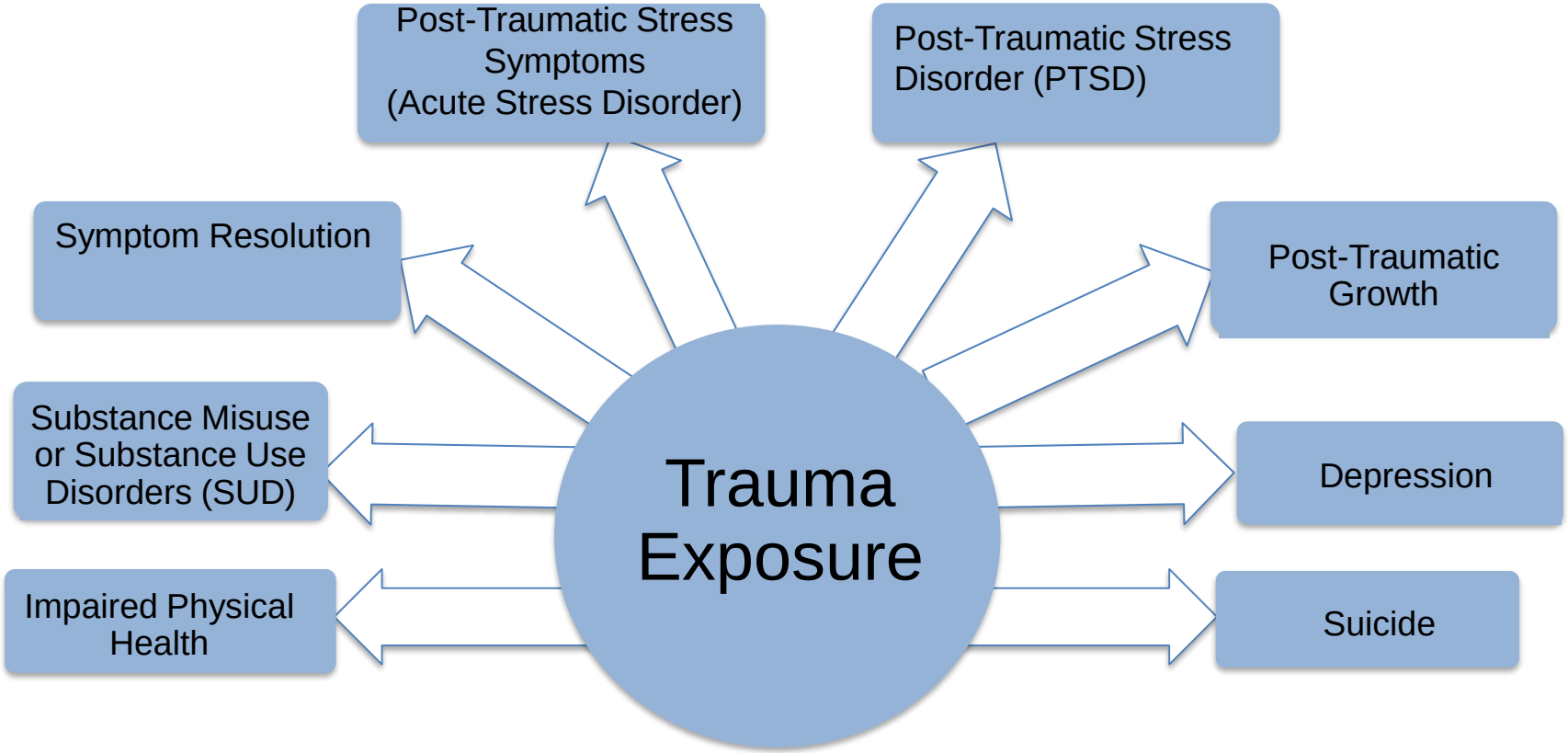
Potential Outcomes After Trauma Exposure



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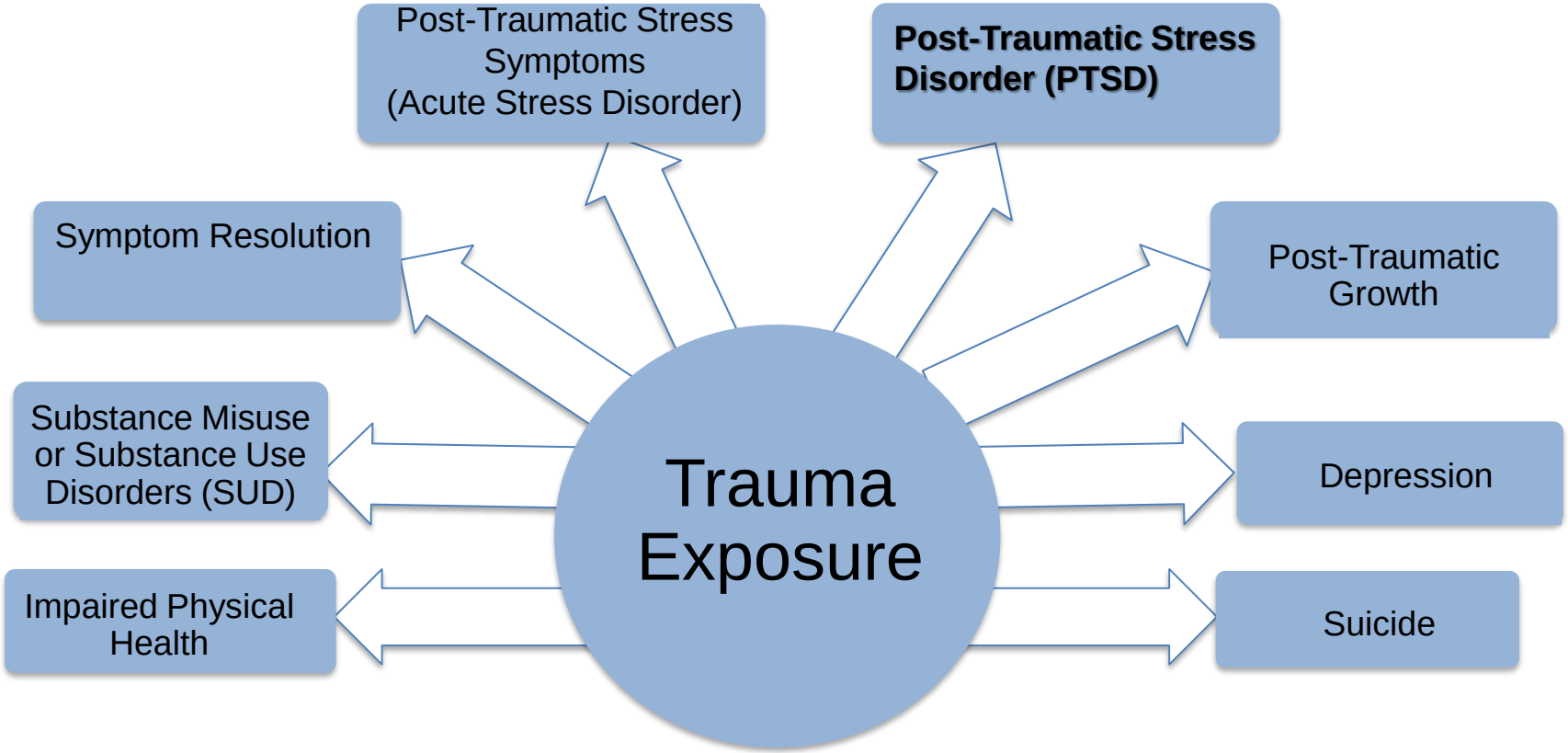
Potential Outcomes After Trauma Exposure



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PTSD Diagnostic Criteria

- According to the American Psychiatric Association Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-5),
  - PTSD is exposure to one or more traumatic events AND subsequent development of characteristic symptoms

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DSM-5 PTSD (APA, 2013)

Trauma Exposure (Criterion A)

Exposure to actual or threatened death, serious injury, or sexual violence in one of more of the following ways:

- Directly
- Witness in person
- Learning the event(s) occurred to close friend or family member. Actual or threatened death - event must have been violent or accidental.

Experiencing repeated or extreme exposure to aversive details of traumatic event(s)

- First responders collecting human remains
- Police officers repeatedly exposed to details of child abuse

Trauma Exposure + **Characteristic Symptoms**

Intrusions (1+)	Avoidance (1+)	Mood/Cognition (2+)	Arousal (2+)
1. Flashbacks 2. Unwanted memories 3. Distressing dreams 4. Psychological distress to reminders 5. Physical reactions to reminders	1. Internal Memories, thoughts, feelings 2. External People, places, situations	1. Reduced recall 2. Negative beliefs 3. Distorted blame 4. Negative feelings 5. Loss of interest 6. Disconnection	1. Irritability or aggression 2. Risky behavior 3. Hypervigilance 4. Exaggerated startle response 5. Concentration difficulties 6. Sleep difficulties

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Additional Important DSM-5 Criteria

- Duration is more than 1 month

- Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of function

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Additional Notes

- Delayed expression can occur
  - Though some symptoms may be present immediately afterward, full diagnostic criteria may not be met until at least 6 months after exposure

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How Is the Diagnosis Typically Made?

- Clinical diagnostic interview (i.e., 90791/90792) by a psychologist, psychiatrist, or psychiatric ARNP

- Diagnostic measures – Gold standard structured clinical interview administered by a trained mental health professional
  - Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)
  - PTSD Symptom Scale – Interview for DSM-5 (PSS-I-5)
  - Structured Clinical Interview for the DSM-5 (SCID PTSD Module)

How Are Symptoms Typically Monitored?

- Screening measures (can be administered via self-report)
  - PTSD Checklist for DSM-5 (PCL-5)
  - Posttraumatic Diagnostic Scale for DSM-5 (PDS-5)
  - International Trauma Questionnaire for ICD-11 (ITQ)

- Clinician queries throughout psychotherapy

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Evidence-Based Treatment for PTSD

- Individual psychotherapies are recommended as first-line. These typically are provided weekly and for 2-4 months duration.
- Across PTSD Clinical Guidelines, the following psychotherapies are recommended:
  - Prolonged Exposure (PE)
  - Cognitive Processing Therapy (CPT)
  - Eye Movement Desensitization and Reprocessing Therapy (EMDR)
    - Some guidelines list EMDR as a conditional recommendation
- Pharmacotherapy is sometimes added as an adjunct when needed
  - FDA-approved adjunct SSRI medications: sertraline, paroxetine
  - Medication management typically is provided less often than psychotherapy. Medications may be needed long-term.

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Therapies with Limited or No Evidence

- Brief Eclectic Psychotherapy (BEP)
- Narrative Exposure Therapy (NET)
- Seeking Safety
- Relaxation
- Ehler’s Cognitive Therapy (CT) for PTSD
- Written Exposure Therapy (WET)
- Stress Inoculation Training (SIT)
- Interpersonal Psychotherapy (IPT)
- Exercise (aerobic or non-aerobic)
- Animal-involved interventions (canine, equine)

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Pharmacotherapy Agents Contraindicated

- Across clinical guidelines, the following pharmacotherapy agents are contraindicated, or considered harmful, at this point:
  - Benzodiazepines – associated with misuse, decreased effectiveness of recommended PTSD treatments, cognitive changes, ineffectiveness long-term, and potentially harmful especially with co-occurring substance use disorders or critical illnesses/injuries.
  - Psychedelics (e.g., ketamine, MDMA-assisted psychotherapy) – risks, adverse effects, may be harmful, and cannot legally be prescribed in the U.S. outside a research study.
  - Cannabis or cannabis derivatives – associated with impaired attention, memory, driving ability, depression, anxiety, substance misuse, paranoia, agitation, suicide attempts, and early and persistent use is associated with emergence of psychosis.

Additional Medications and Therapies with Limited or No Evidence

- Prazosin – blood pressure medication that is used off-label for nightmares. Some studies have shown effectiveness, but many studies show limited effectiveness for PTSD symptom reduction or remission.

- Somatic therapies for which there is insufficient evidence
  - Transcranial Magnetic Stimulation (TMS)
    - Covered with conditions ONLY for Major Depressive Disorder
  - Stellate Ganglion Block
  - Neurofeedback
  - Hyperbaric oxygen therapy
  - NightWare

PTSD Clinical Guidelines in Workers' Compensation

- There are no PTSD clinical guidelines specific for workers' compensation.
- L&I has concerns that some workers with PTSD may not be getting timely access to appropriate diagnosis and evidence-based treatment which would enable them to heal and return to work.
- In order to address patterns of care may be associated with poor outcomes, delayed return to work, prolonged disability, transition to pension, and fatalities:
    - We are developing clinical guidance for evidence-based diagnosis and treatment of PTSD in the Washington Workers' Compensation system.
    - Industrial Insurance Medical Advisory Committee (IIMAC) PTSD Subcommittee composed of experts in the field

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PTSD Clinical Guideline in Workers' Compensation

- We anticipate that our guideline will include many areas pertinent to PTSD that are included in other guidelines including:
  - Diagnostic criteria
  - Assessment and screening
  - Evidence-informed psychological / non-pharmacologic intervention
  - Evidence-based pharmacotherapies
  - Substance use disorder in the context of PTSD
  - Investigational therapies
  - Issues specific to workers' compensation including return to work
    - What does an appropriate treatment course and outcome(s) look like for the customers we serve?
    - What is the anticipated duration of treatment and types of treatment most effective for the customers we serve?
    - What determines the need for escalation of treatment, second opinion, evaluation?

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Mental Health and Behavioral Health: What Are the Differences?

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Mental Health vs Behavioral Health

- According to the American Psychological Association –
  - Psychotherapy is a psychological service provided by a trained mental health professional to treat dysfunctional emotional reactions, ways of thinking, and behavior patterns to treat a mental health condition.
  - Health Behavior Assessment and Intervention services (called BHI at L&I) are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of a physical health condition.

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Behavioral and Mental Health Differences: L&I Lens

Behavioral health intervention is a **brief course of care** with focus on improving worker's ability to participate in recovery and return to work by addressing psychosocial barriers that impede recovery and strengthen coping strategies.

- Appropriate if provider believes psychosocial factors may be affecting medical treatment or medical management of an injury
- Intervention for reactions to injury, recovery, return to work transitions
- **No mental health diagnosis**

Whereas, mental health treatment is for diagnosable mental health conditions that create large impacts to the life of the worker and are excessive reactions by definition.

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Mental Health vs. Behavioral Health: The L&I Lens

- Mental Health (MH) and Behavioral Health (BHI) treatment are two different services with different codes – they are mutually exclusive
    - Mental health treatment is for a diagnosed MH condition
    - BHI is for psychosocial barriers – physical diagnosis

- BHI is not allowed for accepted or denied MH conditions

- MH treatment is not allowable for psychosocial issues that fail to meet DSM-5 diagnostic criteria

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Updated Payment Policy – BHI January, 2024

- Psychologists and Master's Level Therapists (MLTs) may provide service using BHI codes
  - **AP referral required**
  - Required to document the reason for the referral
  - Prior authorization isn't required for initial 16 visits
  - Option to authorize extensions for 8 visits through ONC
    - Or through the SIE / TPA for self-insurance
  - Group is limited to 16 visits (separate from the 16 for individual BHI)
  - No time limit, only visit limit (Frequency up to provider, may be episodic)
  - Individual and group therapy – use specific form F245-461-000

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BHI Criteria

- Recognition of psychosocial barriers
  - Early and timely BHI intervention may help to prevent further dysfunction and disability.

  https://lni.wa.gov/patient-care/advisory-committees/_docs/2019%20PDIR%20Resource_Final.pdf
- Centers of Occupational Health and Education (COHE) use the Functional Recovery Questionnaire (FRQ) screening at 2-6 weeks to identify workers in need

  https://lni.wa.gov/forms-publications/f245-460-000.pdf
- We provide education to Attending Providers (APs) that includes:
  - Identification of psychosocial barriers
  - Relevant interventions and treatment options that are short-term and focused on functional outcomes including return to work

Interaction with Vocational Services

- Vocational Rehabilitation Counselors (VRCs) learn about the worker and determine if/when BHI may be beneficial. They recognize that not all workers will need BHI.
- When the VRC identifies psychosocial barriers, they are addressed and the VRC connects the worker with the appropriate resources and facilitates the Attending Provider referral.
- Vocational Rehabilitation Counselors (VRCs) collaborate with BHI providers to ensure that treatment progresses to prevent unnecessary duration and/or delays.
- VRCs have recognized that **earlier referrals are more effective** than waiting until there are numerous barriers to recovery.

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Overall, How is BHI Impacting Claims?

- Positively, as far as we can tell.
  - We are unable to compare outcomes as we cannot randomize people based on need.
  - However, given claims adjudicator, worker, and VRC viewpoints we can presume that BHI is effective and well-received.
- A survey of 50+ Claims Adjudicators
  - BHI is helpful for workers
  - BHI helps to resolve issues relatively quickly
- Workers have responded positively and the majority have been satisfied and found BHI to be helpful.
- Outside of workers' compensation, there is a huge literature on the effectiveness of health and behavior intervention (i.e., BHI) for coping with medical conditions and adhering to treatment recommendations

Summary

- Injured workers without a diagnosable mental health condition can receive behavioral health services for psychosocial factors impacting recovery
- Post-traumatic stress disorder is the most common diagnosis we receive for mental health only claims
- However, there are a variety of outcomes associated with trauma exposure
- It is important to remain worker-centric and offer appropriate care, delivered in a timely way with limited delays, with a focus on function and returning to work

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Questions

Puzzle image courtesy of Sustainet.com

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Opioid Refresher

SI Colloquium
November 19, 2024

Jaymie Mai, PharmD
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Background

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Opioid Epidemic

- Nearly 645,000 people died from an overdose involving any opioid, including prescription and illicit opioids between1999 and 2021
- Opioid-related deaths has been rising continuously since 1999
- 220 people died each day from an opioid overdose in 2021
- Age-adjusted rates of overdose deaths involving opioids remained stable between 2021 and 2022

Understanding the Opioid Overdose Epidemic | Overdose Prevention | CDC; NCHS Data Brief, Number 491, March 2024 (cdc.gov)

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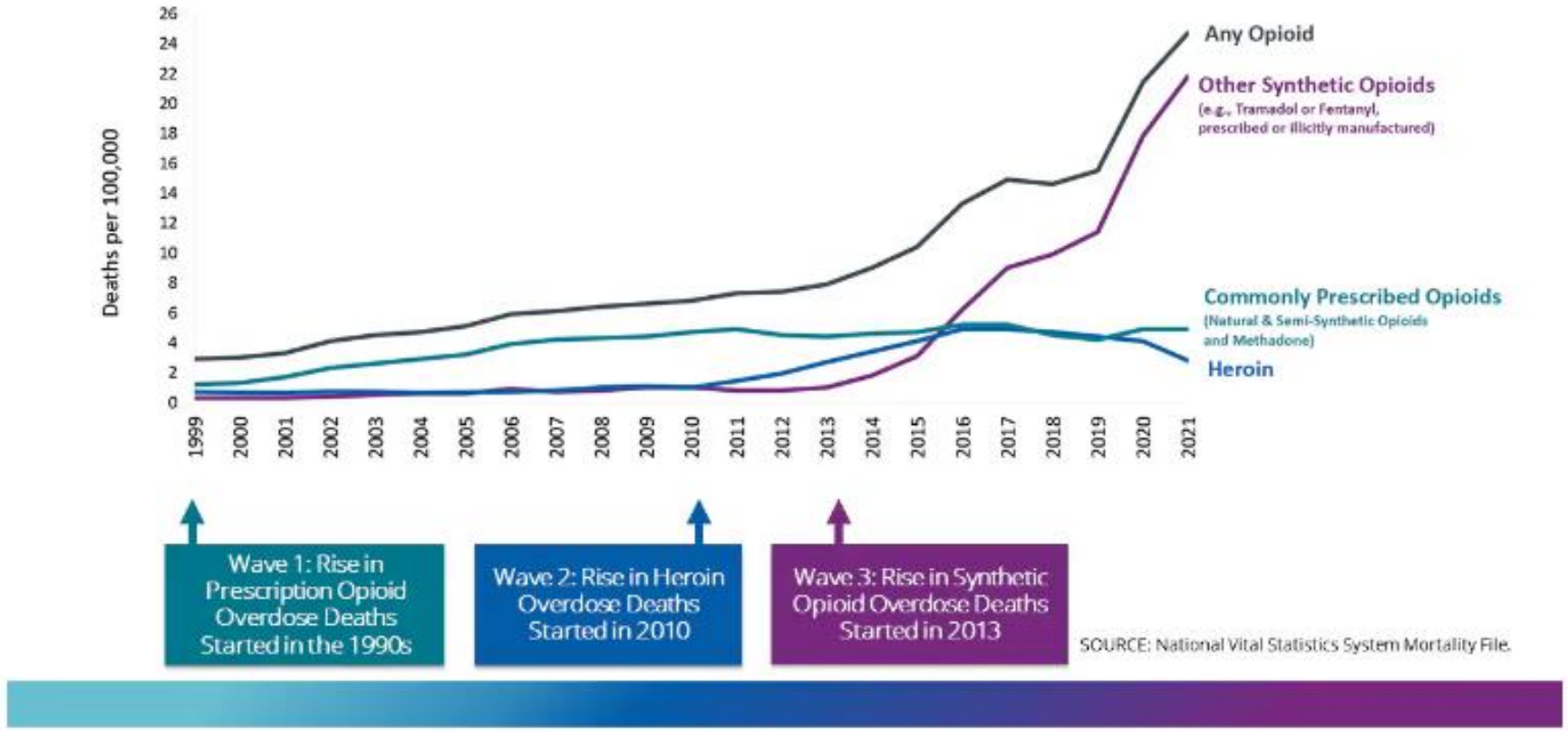
Three Waves of Opioid Overdose Deaths



This rise in opioid overdose deaths is shown in three distinct waves.

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Opioid Use and Disability

- A population-based, prospective cohort looked at early opioid use and disability in the Washington State WC System
  - N=1843 workers with acute low back injury and at least 4 days time loss
  - Baseline interviews were conducted at 18 days(median)
  - 14% were on disability at one year
  - Receipt of opioids for > 7 days, at least 2 opioid prescriptions, or > 150 mg MME doubled risk of disability at 1 year after adjusting for pain, function, and injury severity
- A recent study by the Society of the Actuaries estimates that the opioid epidemic has cost the U.S. economy 631 billion dollars over the past four years

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Other Severe Opioid Adverse Effects

- Acute fractures
- Addiction (opioid use disorder), dependence, tolerance
- Neonatal withdrawal from mothers with chronic opioid use (neonatal abstinence syndrome)
- Decreased endocrine hormones (testosterone & estrogen)
- Sleep disorder (sleep apnea)
- Opioid induced hyperalgesia

Baldini A, Von Korff M, Lin EH. A Review of Potential Adverse Effects of Long-Term Opioid Therapy: A Practitioner's Guide. Prim Care Companion CNS Disord. 2012;14(3):PCC.11m01326. doi: 10.4088/PCC.11m01326. Epub 2012 Jun 14. PMID: 23106029; PMCID: PMC3466038.

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Short-Term Opioid Efficacy and Safety

- Small benefits of opioids versus placebo on short-term pain
  - Mean difference in pain intensity -0.79 point on a 0 to 10 scale
- Opioids associated with small improvement in short-term function
  - Standardize mean difference -0.22 point a -1 to 1 forest plot
- Opioids associated with increased risk of withdrawal due to nausea, vomiting, constipation, dizziness, somnolence, pruritus

Chou R, Hartung D, Turner J, Blazina I, Chan B, Levander X, McDonagh M, Selph S, Fu R, Pappas M. Opioid Treatments for Chronic Pain. Comparative Effectiveness Review No. 229. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No. 20-EHC011. Rockville, MD: Agency for Healthcare Research and Quality; April 2020. DOI: 10.23970/AHRQEPCCER229. Posted final reports are located on the Effective Health Care Program search page.

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Long-Term Opioid Efficacy and Safety

- Opioids associated with decreased likelihood of improvement in pain and no difference in function at 1 year; no differences on either outcome at 2 years
- Opioids were not superior to nonopioid medications for improving pain-related function in moderate to severe chronic back pain or hip or knee osteoarthritis pain
- Opioids associated with increased risk of overdose, all-cause mortality and cardiovascular events (myocardial infarction or cardiovascular mortality)
- Higher dose of opioids associated with increased risk of mortality
- Long-acting opioids associated with increased risk of overdose

Krebs EE, Gravely A, Nugent S, Jensen AC, DeRonne B, Goldsmith ES, Kroenke K, Bair MJ, Noorbaloochi S. Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain: The SPACE Randomized Clinical Trial. JAMA. 2018 Mar 6;319(9):872-882. doi: 10.1001/jama.2018.0899. PMID: 29509867; PMCID: PMC5885909.

Chou R, Hartung D, Turner J, Blazina I, Chan B, Levander X, McDonagh M, Selph S, Fu R, Pappas M. Opioid Treatments for Chronic Pain. Comparative Effectiveness Review No. 229. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No. 20-EHC011. Rockville, MD: Agency for Healthcare Research and Quality; April 2020. DOI: 10.23970/AHRQEPCCER229. Posted final reports are located on the Effective Health Care Program search page.

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2013 L&I Opioid Guidelines and Rules

Image courtesy of LNI.wa.gov

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Opioids in the Acute Phase
(0-6 weeks after injury or surgery)

- Use of opioids as initial treatment for back sprain or other strains isn't supported, but if prescribed, should be limited to short-term (e.g. ≤ 14 days)
- Providers should check the state's PMP before prescribing opioids
- Opioid use should result in CMIF
- Help the worker set reasonable expectations about recovery and return to work
- Opioids won't be authorized beyond 6 weeks in absence of CMIF
- Requirement to use opioids in acute phase WAC 296-20-03055 & WAC 296-20-03065

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Opioids in the Subacute Phase
(between 6 and 12 weeks)

- Opioid use beyond the acute phase is rarely indicated if injury is a sprain or strain
- Provider must perform the following best practices:
  - Screen for opioid risk (ORT, SOAPP-R, DIRE or CAGE-AID)
  - Screen for depression (if indicated) to identify potential impact to treatment
  - Administer baseline urine drug test (UDT)
  - Access PMP to ensure controlled substance history is consistent
  - Document clinically meaningful improvement in function and pain with acute use
- Requirement to use opioids in subacute WAC 296-20-03056

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Opioids at Onset of Chronic Phase
(@ 12 weeks)

- Provider must document the following:
  - CMIF with opioid use in the acute or subacute phase
  - Failure of alternatives to opioids
  - Signed treatment agreement
  - Time-limited treatment plan addressing likelihood of vocational recovery
  - Specialist consultation if dose is ≥ 120mg/d MED
  - No contraindications to the use of opioids
  - No evidence of having serious adverse outcomes from opioid use
- Requirement to start COT WAC 296-20-03057

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Ongoing Chronic Opioid Therapy
(every 12 weeks)

- Provider must document the following:
  - Sustained CMIF or a pain interference score ≤ 4 with stable dosing. If opioid dose is increased, CMIF must be demonstrated in response to dose change
  - Current signed treatment agreement (renew yearly)
  - No relative contraindications to opioids
  - No serious adverse outcomes from opioid use
  - Specialist consultation if dose is ≥ 120mg/d MED
  - No pattern of aberrant behavior has been identified by PMP or UDT
- Requirement for ongoing COT WAC 296-20-03058

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Opioids for Catastrophic Injuries

- Injuries in which significant recovery of physical function is not expected (e.g. severe burns, crush or spinal cord injury)
- Provider must document the following:
  - A current signed treatment agreement
  - Consultation with pain specialist if dose > 120mg/d MED before further dose escalation
  - No relative contraindication to opioid use
  - No evidence of serious adverse outcomes from opioid use
  - No aberrant behavior identified by PMP or UDT
- Requirement for opioids in catastrophic injuries WAC 296-20-03059

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Reviewing Opioid Use in a Claim

Checkmark image courtesy of iStockphoto.com

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Review Medical Records

- Review medical to identify:
  - Chart notes from prescriber with pain interference and pain scores, and documentation of PMP checks at appropriate intervals
  - UDTs repeated at appropriate intervals
  - Treatment agreement (renewed yearly or new agreement with new prescriber)
  - Evidence or likelihood of serious adverse outcomes and contraindications, including vocational impairment
  - Treatment history
  - Pre-injury opioid history, medical comorbidity, concurrent medication
  - Aberrancies, including early refills and duplicative prescribing
- Review drug summary to identify:
  - Non-controlled drug therapy that may impact claim
  - Dosing trends
  - Concurrent CNS depressants

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Consider if COT is Appropriate

- Did worker have sustained CMIF or pain interference with function ≤ 4 from opioid use?
  - Chronic Opioid Request Form (OPI)
- What is the worker's current opioid dose and is it stable?
  - Review drug summary and use opioid calculator to verify current opioid(s) and dose(s)
    - If dose is increased, new CMIF must be demonstrated in response to the dose change
    - If dose is >120mg/d MED, a pain consultation is required before the dose increase
- Are there any "red flags" to opioid use?
  - Aberrant behaviors from UDT, PMP or other sources
  - Multiple prescribers, multiple ER visits, lost medication, "dog ate my pain med", early refills, unauthorized dose escalation
- Is there a treatment agreement on file?
  - Renew yearly or new agreement with new prescriber

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Consider if COT is Appropriate (cont.)

- Is the worker on concurrent sedatives?
  - Review bill summary to verify if there is concurrent sedative use
  - Sedatives include benzodiazepines (e.g. alprazolam, diazepam, lorazepam, triazolam, temazepam), gabapentinoids (e.g. gabapentin, pregabalin), carisoprodol, non-benzodiazepines (e.g. zopiclone, zolpidem, eszopiclone), barbiturates
- Does the worker have any contraindication to opioids?
  - Current substance use disorder except nicotine; history of opioid use disorder; confirmed presence of cocaine, heroin, alcohol or amphetamine/methamphetamine in UDT, etc.
- Does the worker have evidence of or is at high risk for having serious adverse outcomes?
  - Review medical for documentation of symptomatic COPD or CHF, sleep apnea, history of alcohol abuse or overdose, etc.
  - Result from screening tools

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Triggers for Medical Involvement

- Contending severe adverse effect from opioids
  - Bowel impaction
  - Low testosterone or estrogen
  - Central sleep apnea
  - Opioid use disorder (addiction)
  - Fatal or non-fatal overdose
  - Vocational impairment
- Exibiting aberrant behaviors
  - Inconsistent UDT results (confirmed presence of cocaine, heroin, alcohol, amphetamine/methamphetamine or non-prescribed drug; negative for prescribed opioids)
  - Multiple prescribers, requests for early refills or ER/urgent care visits for pain management
  - Lost prescriptions
  - Unauthorized dose escalation
  - Apparent intoxication

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Triggers for Medical Involvement (cont.)

- Concurrent benzodiazepine use
- Repeat request for naloxone – may indicate IW used naloxone to treat a non-fatal overdose
- Questions about UDT or other screening results
- Evidence that opioid use (covered or not) is negatively impacting the claim (including driving/vocational impairment) and prescriber has not responded to outreach
- Request for authorization of treatment for opioid use disorder

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Opioid Use Disorder (OUD)

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“Substance use disorders represent one of the most pressing public health crises of our time”

Surgeon General Vivek Murthy

https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf

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Opioid Use Disorder

- Opioid use disorder is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use opioids despite significant related problems
- OUD is a chronic, relapsing, remitting brain disorder
- The clinical course of opioid use disorders involves periods of exacerbation and remission, but the underlying vulnerability remains
- This clinical trajectory is similar to that of other chronic relapsing conditions (e.g., diabetes and hypertension) in which perfect control of symptoms is challenging and adherence to treatment is often incomplete

Schuckit MA. Treatment of Opioid-Use Disorders. N Engl J Med. 2016 Jul 28;375(4):357-68. doi: 10.1056/NEJMra1604339. PMID: 27464203.
npg-jam-supplement.pdf (asam.org)

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Diagnosis of Opioid Use Disorder

- Diagnostic criteria for OUD is from DSM-5, which requires at least 2 out of 11 criteria over a 12-month period:
  1. Taking opioids in larger amounts or for a longer duration than intended
  2. Persistent desire or unsuccessful attempts to decrease or control opioid use
  3. Excess time spent obtaining, using, or recovering from opioids
  4. Craving opioids
  5. Opioid use interfers with work, home, or school responsibilities
  6. Continuing opioid use despite causing persistent social or interpersonal problems
  7. Reduction in social, occupational, or recreational activities due to opioid use
  8. Using opioids in physically hazardous situations
  9. Continuing opioid use despite causing persistent physical or psychological problems
  10. A need for increased amounts of opioids to achieve desired effect, or diminished effect with continued use of the same dose*
  11. Exhibiting withdrawal symptoms, when opioid dose is decreased and/or taking substances to alleviate withdrawal symptoms*

*Tolerance or withdrawal symptoms don't count if opioid is prescribed

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Medication Assisted Treatment

- Gold standard for treating opioid use disorder is medication assisted treatment (MAT)
- There are three FDA approved MAT
  - —Buprenorphine
  - —Methadone
  - —Naltrexone
- According to the ASAM guidelines on OUD, all FDA approved medications for the treatment of opioid use disorder should be available to all patients.
  - —Clinicians should take into account the patient's preferences, prior treatment history, current state of illness, and the treatment setting when deciding between use of methadone, buprenorphine, and naltrexone

The ASAM NATIONAL PRACTICE GUIDELINE For the Treatment of Opioid Use Disorder at https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_4

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MAT Efficacy

- According to a review article in NEJM, methadone maintenance programs
  - —reduced mortality by approximately 50% among persons with opioid use disorders,
  - —decreased acquisition of HIV infection and hepatitis,
  - —reduced crime and illicit-substance use,
  - —increased social functioning, and
  - —enhanced the rate of retention in rehabilitation programs
- A comparative effectiveness study looking at outcomes for opioid use disorder treatment found that only buprenorphine and methadone were associated with a decrease risk of overdose in the 3 and 12-month follow up period
  - —Treatment with buprenorphine and methadone was also found to be associated with decreases in serious opioid-related acute care in the 3 and 12-month follow up period

Wakeman SE, Larochelle MR, Ameli O, Chaisson CE, McPheeters JT, Crown WH, Azocar F, Sanghavi DM. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA Netw Open. 2020 Feb 5;3(2):e1920622. doi: 10.1001/jamanetworkopen.2019.20622. Erratum in: doi: 10.1001/jamanetworkopen.2024.19798. PMID: 32022884; PMCID: PMC11143463.

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Principles of Treatment

- National Institute on Drug Abuse (NIDA) emphasizes that MAT does not substitute one addiction for another
  - The dosage of medication in MAT does not produce euphoria
  - These medications help to reduce opioid cravings and withdrawal
  - They also work to restore balance to the brain circuits affected by addiction
- OUD is a chronic condition with the potential for both recovery and recurrence, long-term outpatient care and support is essential
- Opioid use disorder often requires continuing care
- Treatment planning should be tailored to the individual and to the family
- Different levels of treatment may be needed by different individuals and/or at different times

Psychiatry.org - Opioid Use Disorder

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Undertreatment of OUD

- A 2024 report from the CDC MMWR found that in 2022, an estimated 3.7% of adults in the United States (9,367,000) needed OUD treatment
  - Among these adults needing OUD treatment in 2022, only 25% received medications for OUD
  - 30% received OUD treatment not including these medications
- A recent retrospective comparative effectiveness study looked at claims from a centralized database of individuals aged 16 years or older with OUD and commercial or Medicare Advantage coverage
  - The authors found that of 40,885 individuals with OUD only 5123 (12.5%) received medication for opioid use disorder treatment with buprenorphine or methadone

Dowell D, Brown S, Gyawali S, et al. Treatment for Opioid Use Disorder: Population Estimates — United States, 2022. MMWR Morb Mortal Wkly Rep 2024;73:567–574. DOI: http://dx.doi.org/10.15585/mmwr.mm7325a1.

Wakeman SE, Larochelle MR, Ameli O, Chaisson CE, McPheeters JT, Crown WH, Azocar F, Sanghavi DM. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA Netw Open. 2020 Feb 5;3(2):e1920622. doi: 10.1001/jamanetworkopen.2019.20622. Erratum in: doi: 10.1001/jamanetworkopen.2024.19798. PMID: 32022884; PMCID: PMC11143463.

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Barriers to OUD Treatment

According to the CDC, factors limit access to medications for OUD include

- Some providers prefer an approach that does not involve medications
- Some falsely equate medications for OUD with illegal substance use
- Methadone for OUD can only be dispensed from a Substance Abuse and Mental Health Services Administration–certified opioid treatment program (OTP)
- Additionally many counties in the country have no OTP
- While buprenorphine or naltrexone can be prescribed in all settings, barriers still exist.
- Many facilities treating OUD do not offer these medications and some do not accept patients using medications for OUD
- In addition, large proportions of pharmacies do not stock buprenorphine
- Payers, including many state Medicaid programs, have restrictions (such as prior authorization) that can delay dispensing of some buprenorphine formulations
- Primary care providers also cite lack of experience treating OUD, lack of access to addiction or behavioral health specialists, and lack of training

Dowell D, Brown S, Gyawali S, et al. Treatment for Opioid Use Disorder: Population Estimates — United States, 2022. MMWR Morb Mortal Wkly Rep 2024;73:567–574.
DOI: http://dx.doi.org/10.15585/mmwr.mm7325a1.

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Substance Use Disorder by Occupation

National Safety Council (NSC) conducted an analysis of Substance Use Disorder by Occupation. They found the prevalence to be

OCCUPATION	Percent
Construction trades and extraction workers	19.0
Service occupations, except protective	15.6
Transportation and material moving workers	13.9
Installation, maintenance and repair workers	13.5
Sales occupations	13.4
Entertainers, sports, media and communications	13.0
Production, machinery setters, operators, tenders	12.9
Executive/administrative/managerial/financial	11.0
Farming, fishing, forestry occupations	10.9
Technicians and related support occupations	10.6
Office and administrative support workers	10.6
Protective service occupations	9.9
Professional (not education/entertainment/media)	8.9
Education, health and related occupations	8.0

https://www.nsc.org/getmedia/9dc908e1-041a-41c5-a607-c4cef2390973/substance-use-disorders-by-%20%20occupation.pdf?srsltid=AfmBOorHdRDxqescAug5npuj2dHBqwPuDZpb1wSqZ75Ou2oR7G5bVAep

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Drug Overdose Mortality by Usual Occupation

The usual occupation group with the highest death rates were

Occupation	Death rate per 100,000 workers
Construction and extraction	162.6
Food preparation and serving-related	117.9
Personal care and service	74.0
Transportation and material moving	70.7
Building and grounds cleaning and maintenance	70.0
Installation, maintenance, and repair	69.9
Production	53.3
Farming, fishing, and forestry	51.3

These occupations had an age-standardized drug overdose death rates with larger absolute values and CIs compared with the drug overdose death rate among workers in all occupations combined.

Billock RM, Steege AL, Miniño A. Drug Overdose Mortality by Usual Occupation and Industry: 46 U.S. States and New York City, 2020. Natl Vital Stat Rep. 2023 Aug;72(7):1-34. PMID: 37639452.

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NSC Recommendations

The NSC report on Substance Use Disorder by Occupation contains recommendations for employers including

- Offer comprehensive health insurance that ensures robust SUD treatment coverage
- Offer robust employer policies and programs
  - Reflect that workers who are in treatment and recovering from addiction are covered by the Americans with Disabilities Act. Employers must provide reasonable accommodations for workers with OUD in treatment programs or in recovery
  - Include Employee Assistance Programs (EAPs) that systematically assesses substance use by workers seeking EAP services, and that it reports on rates of identification of problematic use as well as ensure they use screening tools to better identify risky and unhealthy alcohol and drug use, and link people to appropriate treatment earlier
  - Contain a Worker Peer Support Programs
- Offer a Drug-Free Workplace Program that includes an educational component on workplace substance use

https://www.nsc.org/getmedia/9dc908e1-041a-41c5-a607-c4cef2390973/substance-use-disorders-by-%20%20occupation.pdf?srsltid=AfmBOorHdRDxqescAug5npuj2dHBqwPuDZpb1wSqZ75Ou2oR7G5bVAep

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Opioids and Employment

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Drug and Alcohol in the Workplace

- WAC 296-800-11025 Prohibit alcohol and narcotics from the workplace
  - —Employers must prohibit alcohol and narcotics from the workplace, except in industries/business that produce, distribute, or sell alcohol and narcotic drugs
  - —Employers must prohibit employees under the influence of alcohol or narcotics from worksite
  - —Exemption for employees who are taking prescription drugs, as directed by physician/dentist, if employees are not a danger to themselves or other employees
- In general, prescribed opioids and medications for opioid use disorder are treated like other prescription drugs

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Department of Transportation (DOT) Drug Testing Program

- 49 CFR Part 40
  - Procedures for Transportation Workplace Drug and Alcohol Testing Program
  - Transportation employers, safety-sensitive transportation employees and service agents
- DOT specimens
  - 5 drug classes include marijuana metabolites (including medical marijuana), cocaine metabolites, amphetamines, opioids and pencyclidine (PCP)
  - Opioids include the following opioids - hydrocodone, hydromorphone, oxymorphone, oxycodone, codeine, morphine, 6-acetylmorphine
- Opioid class does not include medications for opioid use disorder (buprenorphine and methadone) or fentanyl

Procedures for Transportation Workplace Drug and Alcohol Testing Programs | US Department of Transportation

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DOT Drug Testing Program (cont.)

- Verification by a Medical Review Officer (MRO) for positive results
  - Must determine if there is a “legitimate medical explanation” including contacting the prescribing provider regarding changes in medication (to one that does not pose a significant safety risk)
- Determination by MRO
  - If there is a significant safety risk remains, s/he must report drug test results and medical information gathered as part of the verification process
  - If there is no significant safety risk, s/he reports drug test result as negative
- Failing a DOT drug test can result in
  - Removal of employee from performing safety-sensitive function
  - Suspension of a commercial driver’s license

Procedures for Transportation Workplace Drug and Alcohol Testing Programs | US Department of Transportation

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Opioid Use Disorder and Americans with Disabilities Act (ADA)

- People with OUD, who are not engaging in illegal drug use, are protected under the ADA.
  - —ADA does not apply to individuals who are currently illegally using drugs
- This includes those who are taking medication for opioid use disorder and those who are participating in a drug treatment program
- Please see the following links for more information: Opioid Use Disorder | ADA.gov and U.S. Department of Justice, Civil Rights Division, Disability Rights Section Technical Assistance document: The Opioid Crisis and the ADA

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Resources

- DOH Provider Toolkits: https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/OpioidPrescribing/HealthcareProviders/Toolkits
- UW Medicine Pain and Opioid Consult Hotline for Clinicians: https://www.hca.wa.gov/assets/billers-and-providers/12-380.pdf
- UW TelePain: https://depts.washington.edu/anesth/care/pain/telepain/mini-site/index.shtml
- Free provider-to-provider UW Psychiatry Consultation Lines: https://psychiatry.uw.edu/clinical-care-consultation/provider-consultation/
- Safe Medication Return: https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/HealthcareProfessionsandFacilities/SafeMedicationReturnProgram

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Images courtesy of proginosko.com, iStockphoto.com and pngbuy.com

OCCUPATIONAL HEALTH **BEST PRACTICES**

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10 Minute Break

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OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

Physical Medicine

Ryanne Karnes, DPT - Therapy Services Manager

Morgan Young, DC – Associate Medical Director for Chiropractic

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Helping workers heal and return to work

- Promoting evidence-based practice
- Improving outcomes for workers
- Preventing work disability

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Morgan Young
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Work Rehabilitation (WR)

Guideline published Oct 2021

Standards published July 2023

Program Implemented February 2024

Image courtesy of https://www.lni.wa.gov/forms-publications/F280-077-000.pdf

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Work Rehabilitation Program

Work Conditioning and Work Hardening under one “special program” policy umbrella.

Assist workers in meeting the demands of a specific job using progressive exercise, work simulation tasks, and education.

Two Intensity Levels – Choose One

1. Work Rehabilitation - Conditioning
2. Work Rehabilitation - Hardening

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Initial Process

Attending Provider makes referral for WR to an approved WR clinic

WR Clinic receives a referral

WR Clinic provides Initial Evaluation

WR Clinic submits authorization request

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Procedure Codes

WR Initial Evaluation

- Does not require prior authorization
- Payable only to approved WR clinics
- Local Code: 1001M

Prior Authorization Required

- WR-Conditioning: Local codes 1023M and 1024M
- WR-Hardening: CPT 97545 and 97546

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Treatment Authorization Criteria

These need to be true to qualify:

1. Requested by an approved WR clinic
2. At least 2 months since injury/illness
3. Attending Provider referral
4. Identified job goal with job title
5. Job description/analysis used to develop plan of care

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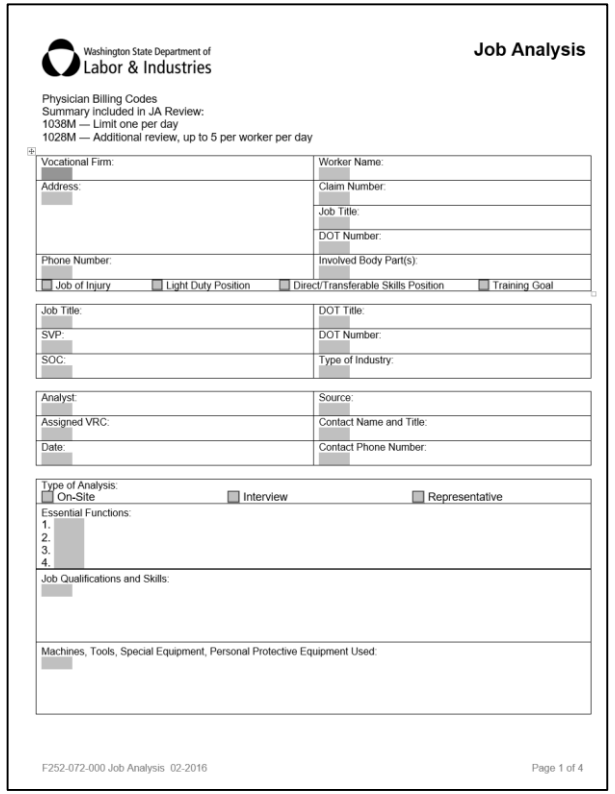
Functional Job Descriptions/Job Analysis (JD/JA)

Ensure adequate detail of the physical demands of the job to help therapist:

- Develop treatment goals
- Accurately identify gaps
- Avoid overexertion
- To develop modified/graduated job options
- More accurate work simulation



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Job Analysis

Physician Billing Codes
Summary included in JA Review:
1038M — Limit one per day
1028M — Additional review, up to 5 per worker per day

Vocational Firm:	Worker Name:
Address:	Claim Number:
	Job Title:
	DOT Number:
Phone Number:	Involved Body Part(s):

☐ Job of Injury ☐ Light Duty Position ☐ Direct/Transferable Skills Position ☐ Training Goal

Job Title:	DOT Title:
SVP:	DOT Number:
SOC:	Type of Industry:

Analyst:	Source:
Assigned VRC:	Contact Name and Title:
Date:	Contact Phone Number:

Type of Analysis:
☐ On-Site ☐ Interview ☐ Representative

Essential Functions:
1.
2.
3.
4.

Job Qualifications and Skills:

Machines, Tools, Special Equipment, Personal Protective Equipment Used:

F252-072-000 Job Analysis 02-2016 Page 1 of 4

Image courtesy of lni.wa.gov

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Vocational Rehabilitation Counselor's Role

- ✓ Plan on having regular return to work (RTW) and modifying job discussions
- ✓ Understand workers concerns and expectations for RTW and ability to share this with the therapy provider
- ✓ Understand workers psychosocial barriers and impact on recovery and strategies to address
- ✓ Help minimize delays and confusion for your client
- ✓ Act on requests for functional JDs/JAs as soon as possible
- ✓ Be ready to participate in WR care conferences every 2 weeks

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Care Conferences

- Care Conferences held every two weeks to discuss progress
- Clinics will invite care team members such as the Vocational Rehabilitation Counselor and Attending Provider

Image courtesy of cansim.ca

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WR Documentation

- Initial Evaluation
- Care Conference Summary (every 2 weeks)
- Progress Reports (every 4 weeks)
- Discharge Capacity Summary

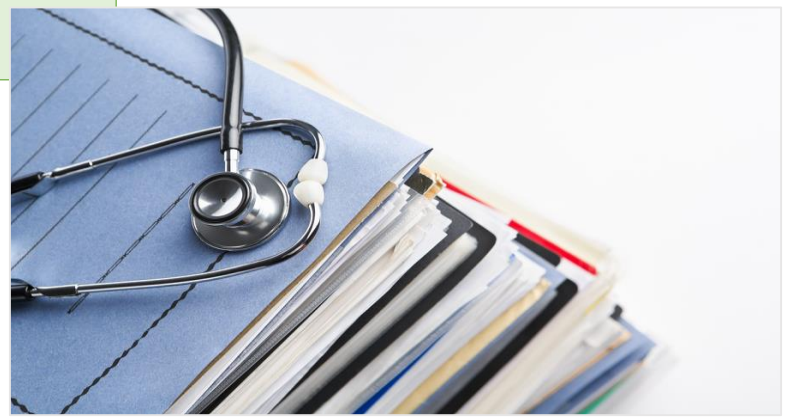

Image courtesy of cansim.ca

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Approved WR Clinics

Required training for WR clinicians – 8 hours

- L&I Workers' Comp Basics
- Psychologically informed practice
- Best Practices
- Pain Neuroscience

List of approved clinics found on L&I website

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Resources

Work Rehabilitation web page

Additional feedback or questions?

L&I Therapy Services Unit:
Therapy@LNI.wa.gov

Image courtesy of swoopanalytics.com

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OCCUPATIONAL HEALTH **BEST PRACTICES**

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Surgical Quality Care Program
SI Colloquium
November 19, 2024

Brooke Allan-Davis
Athena Hightower

Washington State Department of
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Agenda

- Surgical Quality Care Program (SQCP) overview
- Best practices at a glance
- Program participation
- Next steps
- Questions

Brooke Allan-Davis
Athena Hightower
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Overview

2007

- ✓ Ortho Neuro project launch

2014

- ✓ Launch of Surgical Best Practices Pilot (SBPP)

2019

- ✓ SQCP development begins
- ✓ Best practices updated

2023

- ✓ Targeted communication and clinic engagement

2024

- ✓ SQCP transition began

Graphics courtesy of Microsoft PowerPoint

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Best practices at a glance

Best Practice	Importance	Performance threshold
Appropriate Opioid Prescribing	To ensure adherence to the Bree Collaborative	≥ 90% of workers with initial opioid prescription have ≤ 7 days < 5% of workers on opioids moved to chronic opioid therapy ≥ 90% of workers on chronic opioid therapy dosed at ≤50mg/day
Utilization Review	To ensure adherence to L&I medical treatment guidelines	Low and medium adoption: Surgeon must have 80% utilization review approval rate. High and sustaining adoption: Surgeon must have 100% utilization review approval rate.
Submit Activity Prescription Form (APF) before and after surgery	Support clear two-way communication with the workers, employer, and claim manager	At least 85% of surgical claims have pre- and post-surgery APF submitted within 90 days.

Brooke Allan-Davis
Athena Hightower
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Best practices at a glance

Best Practice	Importance	Performance threshold
Perform surgeries within 21 days of authorization	Promotes timely access and minimizes delays in treatment	At least 80% of claim manager authorized surgeries occur within 21 calendar days of the notice of authorization.
Before surgery, establish release-to-work plans and goals with patient	Manage worker expectations	For at least 85% of non-emergent surgical claims (unable to measure without the services of a SHSC).
Review & sign Physical Medicine Progress Report (PMPR) within 14 days.	Coordination with ancillary providers	A surgeon or PA will have reviewed and signed off on 90% of the PMPRs (unable to measure without the services of a SHSC).

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Program participation

- 26 Clinics
- 219 Surgeons
- 12,619 Claims (2023)

Picture courtesy of Microsoft PowerPoint

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Questions

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Neuropsychological vs. Psychological Evaluation

Jennifer Jutte

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When is Neuropsychological Evaluation Needed?

- A neuropsychological evaluation (NPE) is recommended for cases in which central nervous system (CNS)-based impairment in cognitive function, behavior, or emotion is suspected

- Typical referrals are made to:
  - Assist in the diagnosis of certain conditions
  - Describe the impact known neurological conditions are having on a person's cognitive functioning
  - Make practical recommendations for rehabilitation and treatment

Jennifer Jutte
Washington State Department of Labor & Industries

Neurological and Medical Conditions Prompting a NPE

- Traumatic brain injury
- Stroke, other acquired brain injury
- Critical illnesses / injuries
- Hypoxic, anoxic injuries and conditions
- Electrical injuries
- Traumatic amputation
- Chronic pain
- Cancer diagnosis and cancer treatment
- Other conditions thought to affect cognition or brain-behavior relationships

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What Does a Typical NPE Include?

- Comprehensive records review
- Comprehensive, structured interview
  - Developmental, medical, psychological, social, educational, vocational history
  - Current function and symptom presentation
- Consultations with other providers
- Gathering of collateral information
- Deriving conclusions
  - Examination of pattern profiles in the context of history and presentation
- Provision of feedback and recommendations
  - Specific intervention, follow-up, and work-related recommendations
- Assessment of brain functioning through observation of behavior

What Does a Typical NPE Include?

- Assessment of brain functioning through interactive measures to assess:
  - Intellectual functioning
  - Academic abilities
  - Attention and concentration
  - Verbal and visual memory
  - Motor and visual-motor functioning
  - Language skills
  - Concept formation, reasoning, problem solving, and executive skills
  - Emotional status

Measures May Include (e.g., moderate-to-severe Traumatic Brain Injury)

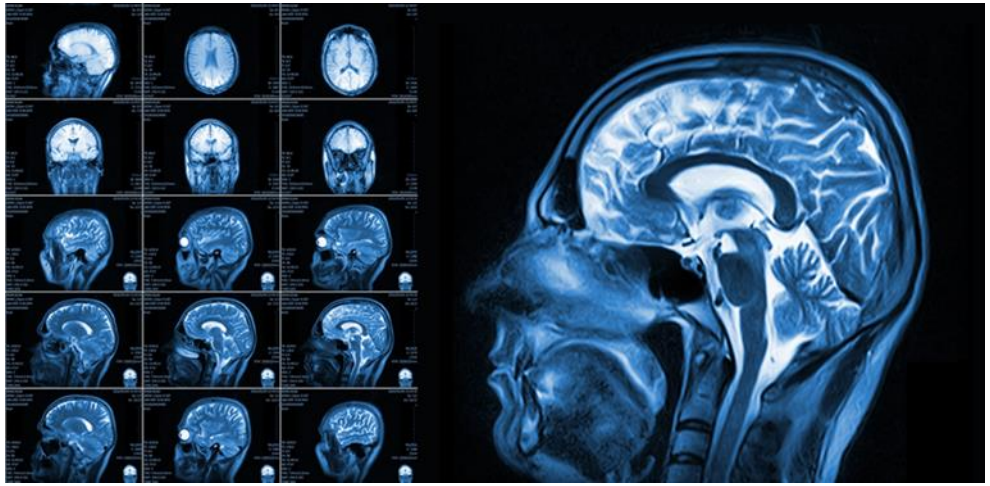
- Attention and Working Memory (e.g., Paced Serial Addition Test, WAIS-IV subtests/WAIS-V beginning August, 2024, WMS-III Spatial Span)
- New Learning and Retrieval (e.g., CVLT, HVLT, RAVLT, WMS-IV logical memory, WMS-IV visual reproductions, BVMT-R)
- Processing Speed (e.g., WAIS-IV/WAIS-V processing speed index, Trails A, SDMT)
- Executive Functions (e.g., COWAT, D-KEFS, Trails B, WCST)
- Psychological Symptoms (e.g., MMPI-3, BDI-II/PHQ-9, BAI/GAD-7, CAPS-5, PCL-5)
- Effort (e.g., WMT, TOMM)
- Post-concussive Symptoms (e.g., Neurobehavioral Symptom Inventory)

Purpose of a NPE

- To provide information on brain functions
- To characterize cognitive strengths and relative weaknesses
- To objectively track cognitive changes
- To provide adjunct diagnostic work-up (differential diagnosis)
- To establish a baseline for known illness or injury
- To evaluate medication efficacy / toxicity
- To assist with rehabilitation, psychosocial, and treatment interventions
- To evaluate return to work / school issues

What Does a NPE Really Add?

- Why not just use a scan? Why bother with a NPE at all?
  - They are cumbersome
  - They take a lot of time
  - They cost more money
  - Allied staff can give screening instruments, so why bother with a full neuropsychological evaluation??



X-Ray image courtesy of swdic.com

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Brain Scans

- MRI, CT, EEG are essential in diagnosis, but relatively poor predictors of functional outcome.

- Most neurodiagnostic studies have limited use in terms of making specific behavioral, educational, or functional recommendations.

- Pictures don’t provide any information about actual brain function.

X-Ray image courtesy of swdic.com

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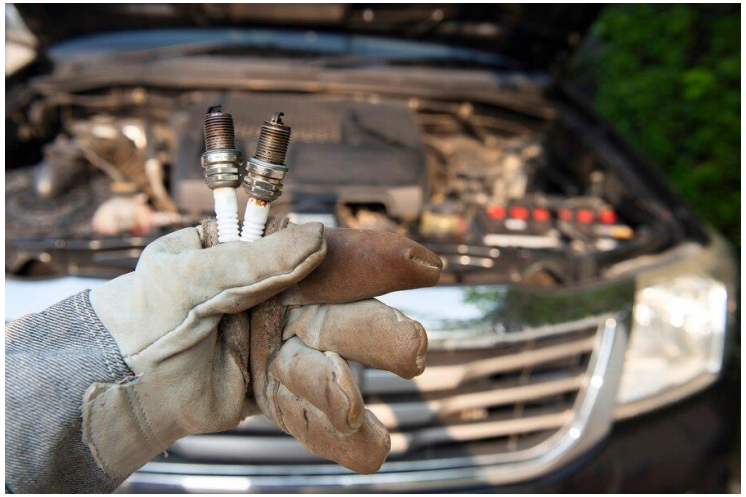
What's the point?



- Imaging does not tell you about **HOW** a brain functions.
- A neuropsychological evaluation is like a test drive to see how well a car runs.
- In contrast, an MRI gives a static picture of the brain.
- It would be like watching a car engine run, but not move, and would not show how the engine works in action.

Spark plug image courtesy of freepic.com

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Washington State Department of Labor & Industries

Summary

- Clinical neuropsychology is a specialty field within clinical psychology
- Neuropsychologists understand relationships between brain and behavior applied to:
  - CNS disorder diagnoses
  - Assessment of cognitive and behavioral function
  - Treatment recommendations (including referral and/or intervention)
- Neuropsychologists are skilled at integrating multiple data points and identifying patterns to guide diagnosis and treatment recommendations
- Neuropsychological evaluations are essential for making specific behavioral, educational, or functional recommendations

What is a Psychological Evaluation and How is it Different from a Neuropsychological Evaluation?

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Psychological evaluation

- Also called a psychodiagnostic evaluation
- Comprehensive records review (SAME)
- Comprehensive, structured interview (SAME)
  - Developmental, medical, psychological, social, educational, vocational history
  - Current function and symptom presentation
- Consultations with other providers (SAME)
- Deriving of conclusions (SAME)
  - Examination of pattern profiles in the context of history and presentation
- Provision of feedback and recommendations (SAME)
  - Specific intervention, follow-up, and work-related recommendations
- Gathering of collateral information (SAME)

Psychological evaluation

- Designed to ask questions pertaining to psychological, emotional, motivational, behavioral, and interpersonal function (DIFFERENT)
  - A neuropsychological evaluation is recommended for cases in which CNS-based impairment in cognitive function, behavior, or emotion is suspected

- Assessment of psychological, emotional, and interpersonal functioning through behavioral observations and standardized measures (DIFFERENT)
  - Assessment of brain functioning through behavioral observations and standardized measures

Jennifer Jutte
Washington State Department of Labor & Industries

What Measures Does a Typical Psychological Evaluation Include?

- Psychological measures
  - Comprehensive assessment of psychopathology (MMPI-3, PAI)
  - Diagnostic measures
  - Additional measures pertinent to the presenting issues, or suspected issues (e.g., depressive symptoms, general anxiety symptoms, post-traumatic stress symptoms)

- Brief cognitive measure, if needed
  - For example, MoCA, MMSE, RBANS

Summary

- A neuropsychological evaluation is recommended for cases in which CNS-based impairment in cognitive function, behavior, or emotion is suspected.

- A psychological evaluation is designed to ask questions pertaining to psychological, emotional, motivational, behavioral, and interpersonal function

- Each of these types of evaluation can be instrumental in determining diagnosis, treatment recommendations, functional recommendations, and return to work and school recommendations

Jennifer Jutte
Washington State Department of Labor & Industries

What can be done with the results?

- Medical providers
  - Make better informed medical management decisions
  - Identify which problems are most relevant
  - Identify appropriate referrals
- Employer
  - Better understand the problem(s)
  - Understand likely prognosis including return-to-work
  - Know what to expect and what NOT to expect
  - Identify ways they can help (e.g., relevant accommodations)
- Vocational providers
  - Tailor intervention / recommendations to available strengths and relative weaknesses

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Washington State Department of Labor & Industries

Questions

Puzzle image courtesy of Sustainet.com

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Washington State Department of Labor & Industries

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Physician Assistant (PA) WAC Update
November 19, 2024

Marc Hobbs

Washington State Department of Labor & Industries

What's changing?

- WAC 296-20-12501 limits reimbursement to physician assistants (PAs) to 90% of our fee schedule rates.
- We are repealing WAC 296-20-12501 entirely.
- The other parts of the WAC are reflected in payment policy or other WACs, so they aren't needed.

Why make the change?

- The 90% differential was put in place when PAs had to be supervised by other providers and couldn't practice independently.
- A law passed during the 2024 session made it possible for PAs to form "collaborative agreements". This means they can practice independently.
- Because L&I allows PAs to be Attending Providers (APs), we believe they should be paid the same way as other APs.

What's next?

- The rulemaking process is underway. A hearing is scheduled for December 4, 2024 at 3pm.
- We've sent a letter to all PAs in our network informing them of the change. We're also in communication with WAPA, the professional association for PAs in Washington.
- Other changes resulting from the new law are being handled by Jami Lifka from the Office of the Medical Director. This rulemaking only affects the pay differential.
- We expect the change to go live on March 1, 2025. From that date forward, PAs will be paid up to 100% of fee schedule rates.

THANK YOU!
QUESTIONS?

Email hobm235@Lni.wa.gov

Marc Hobbs
Washington State Department of
Labor & Industries

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Naturopathic Payment Policy Updates
November 2024

Tina Vorse

Washington State Department of
Labor & Industries

Agenda

- Changes made to naturopathic payment policy – what changed, what didn't, and why the updates were made.
- How it's going.
- What's next.

Presented by:
Tina Vorse, CPC
Project Manager
Healthcare Policy & Payment Methods
Health Services Analysis

Changes – Prior to the update

- Naturopaths previously billed with a set of provider-specific L&I local codes.
  - Long standing payment structure
  - Local codes included office visit + any treatment performed that day

- Only able to bill for a very limited number of services outside L&I local codes.
  - Examples: diagnostic testing, reports and forms for attending providers, telephone calls, online communications

Changes – Why L&I made updates

- Naturopathic community expressed that the previous payment model and policy was confusing.

- National office visit code changes have affected how L&I has priced & leveled ND local codes in the past.

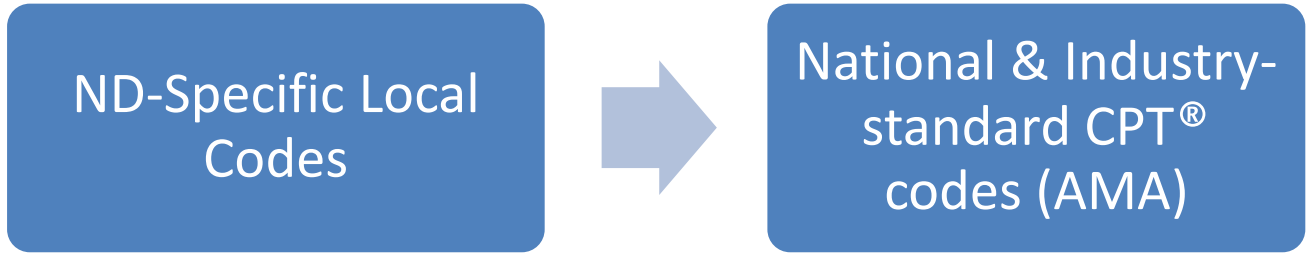
- Research & data analysis didn't support a need for the previous payment model.
  - ND reimbursement was not aligned with other APs
  - Increased administrative burden on NDs
  - Didn't support consistency in billing/coding practice of other payers
  - Lack of visibility for L&I to track & monitor treatments being performed by NDs.

Changes – Why L&I made updates

- Using CPT® provides more variable reimbursement based on the service rendered.
  - More coding options that are separated out
  - More reflective of the work NDs are doing during any given visit
  - Alignment with other Attending Provider types
- Projected an insignificant increase to reimbursement given naturopaths' current practices.
  - Cost containment measures already in place: established national coding guidelines, department rules, policies & fees for these services.
- Conservative care limits are already established:
  - One visit per day, per worker, per provider
  - 60 days/20 visits report or comprehensive visit documentation
  - 120 day consult (must refer out)
  - Service limitations for commonly used treatments by naturopaths

Changes – What changed?

- How naturopaths bill & are reimbursed for their services (coding):



  - Separate reimbursement for the appropriate level of each service provided

- Updates to naturopathic WACs to remove mention of local codes and bundling of treatment in office visits.
  - Updated WAC 296-23-205
  - Repealed WAC 296-23-215

Tina Vorse
Washington State Department of Labor & Industries

Changes – What didn't change?

- No changes to the services NDs provided
  - Only changed how naturopaths bill & are reimbursed for services

- Services that L&I covers for naturopaths:
  - Homeopathic treatments, minerals, botanicals or other similar remedies remained non-covered as they are for all providers.
  - Long-standing non-coverage of consultations remained

- Requirements are applicable to all providers

Tina Vorse
Washington State Department of Labor & Industries

How it's going

- Stakeholdering during the project was overwhelmingly positive regarding L&I making these changes – hasn't changed

- Transition seems to be going smoothly – naturopaths were already billing this way for other insurers.

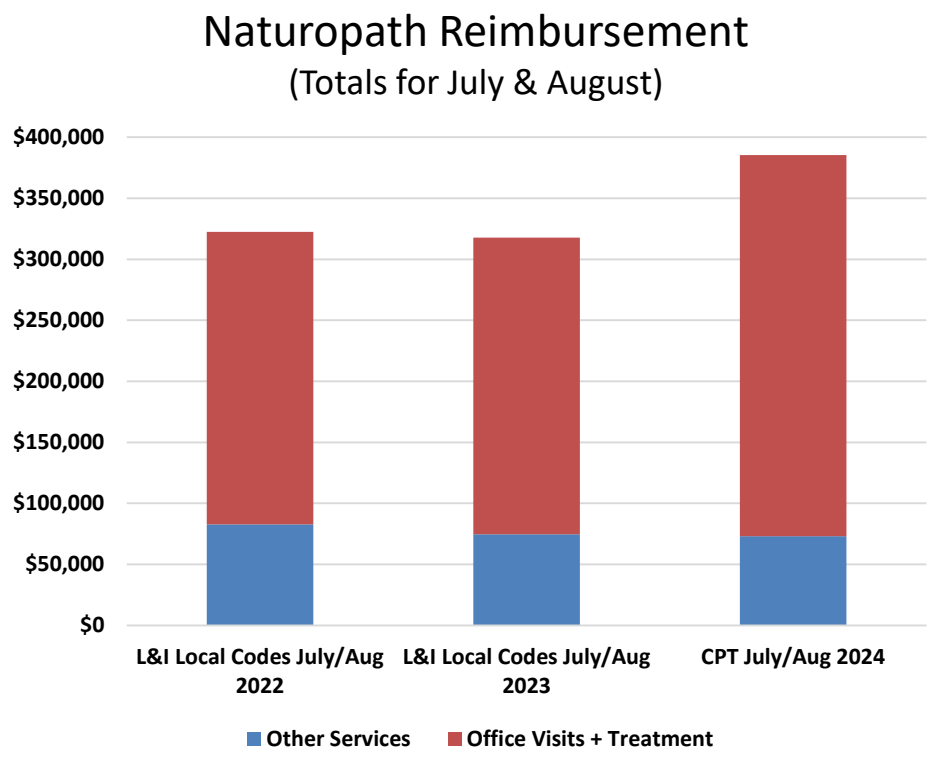
- Currently monitoring billing data – limited as providers have 1 year from the date of service to bill.

Tina Vorse
Washington State Department of Labor & Industries

Overview: Cost Comparisons

Limited data shows current trends:

- Overall naturopath reimbursement has been similar to the same months in 2023.
- Reimbursement for office visits + treatment increased slightly as projected (28% increase so far).
- Note: Processed approx. 200 less office visits than previous years.



*Limited data for 2024 due to timely filing requirements. Providers have 1 year from the date of service to bill.

Tina Vorse
Washington State Department of Labor & Industries

What's next?

- L&I will continue to monitor implementation of these changes to the naturopathic payment policy.

- Continuing to monitor DOH sunrise review on naturopathic scope of practice (prescribing) for potential future payment policy updates.

Tina Vorse
Washington State Department of Labor & Industries

THANK YOU!
QUESTIONS?

Please reach out to HPPM@Lni.wa.gov with any additional questions.

Tina Vorse
Washington State Department of Labor & Industries

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Psychologists as Attending Providers
November 19, 2024

Jami Lifka

Washington State Department of
Labor & Industries

HB 1197 Psychologists as attending providers in claims solely for mental health conditions (Chapter 171, Laws of 2023)

What is the purpose of the bill?

- Improve access to treatment in claims solely for mental health conditions.
- Allow psychologists to be the attending provider.

What is an example of a condition being treated by a psychologist?

- Posttraumatic stress disorder (PTSD) as an occupational disease.
  - First responders that experience repeated exposure to traumatic events.
  - Law enforcement officers exposed to details of child abuse.

What are claims that are “solely for mental health conditions?”

- There is a mental health diagnosis on the claim (e.g. PTSD).
- No physical conditions are treated as part of the claim at any point in the life of the claim.

When is the bill effective?

- July 1, 2025.
- Applies retroactively.

Jami Lifka
Washington State Department of Labor & Industries

HB 1197: “Attending provider” in statute

“Attending Provider” means:

- A person who is a member of the health care provider network, is treating injured workers within the person’s scope of practice, and is licensed under Title 18 RCW (Department of Health), in one of the following professions:
- Physician, osteopathy, chiropractic, naturopathy, podiatric medicine and surgery, dentistry, optometry, psychology in the case of claims solely for mental health, physician assistants, and licensed advanced registered nurse practitioners.

WAC 296-20-01002 Definitions: "Attending provider" in rule

Current rule language

- Attending provider: For these rules, means a person licensed to independently practice one or more of the following professions:
- Medicine and surgery; osteopathic medicine and surgery; chiropractic; naturopathic physician; podiatry; dentistry; optometry; and advanced registered nurse practitioner.

Draft rule language – effective July 1, 2025

- Attending provider: For these rules means a person who is a member of the health care provider network, is treating injured workers within their scope of practice, and is licensed under Title 18 RCW, as one or more of the following:
  - Physician, osteopathic physician, chiropractor, naturopathic physician, podiatric physician, dentist, optometrist, advanced registered nurse practitioner, **psychologist in claims solely for mental health conditions, and physician assistant.**

Jami Lifka
Washington State Department of Labor & Industries

Rule Amendments Necessary to Implement: HB 1197

WAC 296-20-01002 **Definitions** – "Attending provider"

- Add psychologists in the case of claims solely for mental health conditions, and physician assistants.

WAC 296-20-01010 **Scope of health care provider network**

- Add "psychologists"

WAC 296-20-01501 **Physician assistant rules**

- Clarify that physician assistants can be attending providers.
- Align with ESHB 2041 (Chapter 62, Laws of 2024) **Physician assistant collaborative practice.**

WAC 296-20-06101 **What reports are health care providers required to submit to the insurer?**

- Add "psychologist in the case of claims solely for mental health conditions" to the "Special notes" column:
  - Who can sign and be paid for completion of the ROA and PIR?
  - Who can sign and be paid for completion of the application to reopen the claim due to worsening of the condition?

Jami Lifka
Washington State Department of Labor & Industries

Amend Terms within WAC 296-20-01002: Definitions to be consistent with HB 1197

Examples:

Replace “attending doctor” or “doctor” with “attending provider” or “provider”

- Attending provider report
- Consultation examination report
- Fatal
- Modified work status
- Proper and necessary
- Regular work status
- Temporary partial disability
- Total permanent disability

Jami Lifka
Washington State Department of Labor & Industries

Amend other WACs to be consistent with HB 1197

Examples:

Replace “attending doctor” with “attending provider”

WAC 296-20-09701 Request for reconsideration

- A claim may be closed prematurely … **the attending doctor** should submit immediately in writing his request for reconsideration of the adjudication action.

WAC 296-23-250 Massage therapy rules

- Massage therapy treatment will be permitted when given by a licensed massage practitioner only upon written orders from the worker’s **attending doctor.**

Jami Lifka
Washington State Department of Labor & Industries

Amend other WACs to be consistent with HB 1197

Examples:

Replace “attending physician” with “attending provider”

WAC 296-19A-140 What information must a provider include in a labor market survey?

- A summary of whether or not the industrially injured or ill worker has the physical and mental/cognitive capacities to perform the job, based upon information from the **attending physician** or from a preponderance of medical information.

WAC 296-23-246 Attendant services

- To be covered by the department, attendant services must be requested by the **attending physician** and authorized by the department before care begins.

Jami Lifka
Washington State Department of Labor & Industries

Amend other WACs to be consistent with HB 1197

Examples:

Replace “attending health services provider” with “attending provider”

WAC 296-14-6226 What other information must be submitted to the department in a completed application for a residence modification?

- The **attending health services provider** may need to submit medical documentation verifying the worker's condition and the necessity for any residence modification.

WAC 296-14-6236 How is a worker advised that the supervisor has approved or denied the request for residence modification benefits?

- The department will notify the worker, contractors, homeowner (if not the worker), residence modification consultant **attending health services provider** and employer of the supervisor's decision in writing.

Jami Lifka
Washington State Department of Labor & Industries

Proposed rulemaking timeline

File CR-101 Considering rulemaking

- September 17, 2024

File CR-102 Proposing language

- December 17, 2024

File CR-103 Adopting final language

- May 6, 2025
- Effective July 1, 2025

L&I contact: Jami.Lifka@Lni.wa.gov

Rulemaking Questions?

Jami.Lifka@Lni.wa.gov

OCCUPATIONAL HEALTH **BEST PRACTICES**

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Medical Consultant Program Update

Amy Updike

Washington State Department of
Labor & Industries

OCCUPATIONAL HEALTH **BEST PRACTICES**

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10 Minute Break

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Stump the Docs

Jennifer Jutte
Gary Franklin

Washington State Department of
Labor & Industries

Stump the Docs

Moderator

- Knowrasa Patrick, Self Insurance Program Manager

Docs

- Jennifer Jutte, Associate Medical Director
- Gary Franklin, Medical Director

Discussion Topics

Behavioral and Mental Health
Neurology/Neuropsychological Testing

OCCUPATIONAL HEALTH **BEST PRACTICES**

WORKING TOGETHER TO KEEP PEOPLE WORKING

Closing Remarks & Takeaways

Kris Tefft

Washington State Department of
Labor & Industries

Continuing Education Credit Information

Course Title: 2024 Self Insurance Colloquium - Occupational Health Best Practices

1. This course has been pre-approved by L&I's Self-Insurance Continue Education Curriculum Advisory Committee to provide continuing education credit for completion of the identified course.
   - The course is approved for **3.0** CE contact hour(s).
   - Course ID number: **004-1024-0333**
   - Course Approval Number: **WA2024-645**

2. This program has been pre-approved by The Commission for Case Manager Certification to provide continuing education credit to CDMS® board-certified disability management specialists.
   - The course is approved for **3.0** CE contact hour(s).
   - Activity code: **S00001153**
   - Approval Number: **240000336**

Please note:

- **Attendees must complete the Post Event Evaluation/Survey to receive a Certificate of Completion.**
- Post Event Evaluations/Surveys will be sent tomorrow via your registration email.
- **The Evaluation/Survey must be completed by December 4, 2024**.
- Certificates of Completion will be emailed after the Post Event Evaluation/Survey window closes.

Questions: SIColloquium@LNI.WA.GOV

Thank you!

Knowrasa Patrick
Washington State Department of
Labor & Industries