Surgical Health Services Coordinator

Program Manual

Washington State Department of
Labor & Industries

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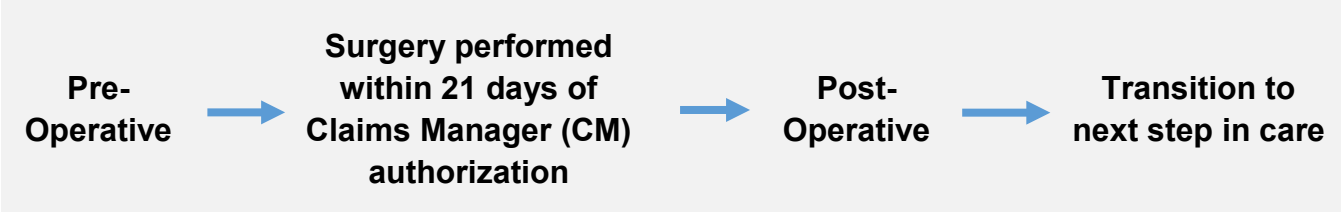
What the Surgical Quality Care Program is about

The Surgical Quality Care Program (SQC Program) is a pay-for-quality program developed by the Washington State Department of Labor & Industries (L&I). It rewards musculoskeletal surgeons for mastery of specific best practices. To help the surgeons and workers alike, L&I created the Surgical Health Services Coordinator (SHSC) role. For specifics about the best practices and surgeon participation, refer to the SQC Program Manual.

How the Surgical Health Services Coordinator fits in - Your keys to success

A Surgical Health Services Coordinator (SHSC) offers an important contribution to workers recovery following surgery. As a liaison between the attending provider(s), surgical provider(s), worker(s), employer(s) and claim manager(s), your mission is to coordinate clinical care and work outcomes. If a Vocational Rehabilitation Counselor (VRC) is assigned, don't duplicate services – the VRC leads the return-to-work (RTW) efforts.



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SQCP Phases

Pre-Operative	Post-Operative	Transition to next step in care
Surgeon: ■ Determines need for surgery ■ Discusses post-op, release to work goals with worker ■ Completes pre-surgical Activity Prescription Form (APF) **SHSC:** ■ Transition to surgical care ■ Administers Graded Chronic Pain Scale[1] ■ Documents worker expectations and goals ■ Notifies surgeon of any red flags ■ Helps resolve any issues causing surgery delay ■ Contacts employer (i.e. light duty) ■ Creates coordination plan	**Surgeon/PAC/ARNP:** ■ Assess/document status and rehab plan ■ Reinforce release to work goal ■ Reviews and signs Physical Medicine Progress Report ■ Completes at least one post-op APF **SHSC: (recurring)** ■ Monitors surgeon treatment plan ■ Follows referrals, intervenes as necessary ■ Administers Graded Chronic Pain Scale[1] ■ Identifies "stalls" (e.g. pain, delayed recovery/release to work, etc.) ■ Communicates "stalls" to surgeon, discusses interventions (e.g. Progressive Goal Attainment Program (PGAP); Functional Capacity Evaluation (FCE), work hardening, etc.) ■ Updates coordination plan	**Surgeon:** ■ Treats throughout global surgical period ■ If not Maximum Medical Improvement (MMI), documents next steps ■ Discusses MMI or transition with worker **SHSC** ■ At about 120/150 days (depending on surgery) checks treatment plan ■ Begins discussion with surgeon to prep for considering transition at next visit ■ Assists finding new Attending Provider (AP) if needed ■ Hand-off to new AP

1. Referred to as the Pain and Function Scale (PFS) in both this Toolkit and in OHMS.

WHAT IS THE SURGICAL HEALTH SERVICES COORDINATOR TOOLKIT?

The toolkit guides SHSCs working with surgeons enrolled in L&I's Surgical Quality Care Program. A few things to remember when using this toolkit:

- We refer to your patients who are injured workers as "workers" throughout this toolkit as well as in the SQCP Manual.
- Though we refer to 'the surgeon' throughout this toolkit, a PA-C or ARNP may perform the activities in the respective area(s) with the exception of:
  - Determining surgery is necessary, and
  - Conducting the pre-op appointment, and
  - Documenting the estimated release to work plans and goals.

CONFIDENTIALITY

You signed a confidentiality agreement that grants you access to the Claim and Account Center (CAC) with private worker and employer information. Remember, all L&I claim information is for official use only. Please restrict yourself to your assigned claims. You may not share information about any injured worker or employer outside of your official duties.

OCCUPATIONAL HEALTH MANAGEMENT SYSTEM (OHMS)

SHSCs utilize the Occupational Health Management System (OHMS). It supports the implementation and tracking of existing and emerging occupational "Best Practice" programs. It's not a single system, but rather a group of systems that work together to facilitate coordination of care between providers, employers and injured workers. MAVEN is part of the system that supports care coordination and you may see/hear it used interchangeably with OHMS.

Why is this important to me?

The OHMS system documents your work in MAVEN, and is essential in order to bill for your services.

1. To learn more about assigning claims to your caseload, documenting claims and billing for your work in MAVEN, go to http://ohms.apps.Lni.wa.gov/ohmsdocs/OHMSSurgicalUserGuide.pdf .

Document all of your activities in MAVEN SHSC case notes.

You document your activities by creating an SHSC case note. Do this each time you provide services to: a worker, your providers, the employer, claim manager other care providers or vocational counselors. At a minimum, we expect you to document:

1. Name of contacted party including their title/role and nature of discussion.
2. What activities you performed to help move the worker towards recovery and release/return to work.
3. Any barriers to recovery and release/return to work.
4. Most importantly, document your care coordination plan (i.e. what you need to do and by when, who you need to contact or consult, as well as how this will help move the worker to recovery and/or release/return to work).

Only documented services are billed/paid

We have provided a one page billing status key, Health Services Coordination Activities Checklist, at Appendix #1. We recommend you print a copy of this key and keep it handy as a quick reference.

MAVEN also tracks your work

Use MAVEN Lists to help you track your caseload and meet care coordination and SQC Program goals.

1. Detailed information about SHSC worklists and setting tasks is contained in the OHMS User Guide.
2. The SHSC User Guide is located at the bottom of your OHMS login page.
    - You may also go to the SHSC User Guide by using this link **http://ohms.apps.Lni.wa.gov/ohmsdocs/OHMSSurgicalUserGuide.pdf**

3. We recommended you plan your work day/week by choosing a time of day or day of the week to review each work list (see example on the next page, fig 1.1).

MAVEN data informs the SQC Program

Activities you document in your case notes provide information needed for SQC Program best practices. For now, the only method to score two of the surgeon's measures is for you to document them in MAVEN.

1. Surgeon's pre-op RTW discussion with the worker is essential to setting expectations about return to work.
2. Surgeons' (or PA-C) signature and return of Physical Medicine Progress Report (PMPR) demonstrates that the surgeon is involved in the workers' post-op rehabilitation.

Fig 1.1

Work List Name	Recommended Review Frequency	Example	Suggestions
Surgical Claims list	At least once daily	Morning and afternoon	New claims will arrive to your list throughout the day. Sort your list by "SHSC Case Note Submitted" to find claims that have not been worked in 45–60 days and may have been missed.
Post-op Claims list	At least once or twice weekly	Morning and afternoon	Checking daily for PFS, RTW dates and helps to avoid missed goal dates.
Task list	At least once daily**	Morning and afternoon	You can raise the priority of tasks that are remaining at the end of the day.
Claims Shared With Me list	At least once weekly	Choose a day of the week and add this to your scheduled work	To find claims that have been shared with you by others and move them to your SHSC Work List or bulk action them, as appropriate.

*** You may not need to create a task on every claim if you use other work lists consistently. This keeps your task list shorter, avoiding duplicate work. Look for our handout in the appendices.*

SHSC Standard Work

Beginning in July 2019, L&I established Standard Work areas for SHSCs. L&I developed these new Standard Work areas based on existing care coordination best practices.

SHSC STANDARD WORK CATEGORIES

- Transitions of care
- Surgical care (Pre and post-op)
- Barrier assessment tools — The Pain and Function scales
- Clinical referral coordination/tracking
- Ongoing monitoring
- Community services referrals
- Communicating medication issues

Note: Not every Standard Work category is included in every case note or even on every claim.

We want you to meet the worker wherever they're on their road to recovery each time you work on their claim (e.g. you may or may not need to transition workers to surgical care if their attending provider is already a surgeon in your clinic).

SURGICAL STANDARD WORK PHASES

We recognize that not every worker seen in your clinic will have surgery — you may provide services to many workers receiving conservative care. It's important to update the phase of work in MAVEN to reflect where the worker is in their treatment. Not every phase is required for every worker.

The phase will show up on your work lists and help to plan/prioritize your work. The phases are:

- Initial Review: A holding pattern before an initial appointment with little/no other information.
- Consultation: Treatment plan is pending diagnostic tests or other considerations.
- Conservative Care: Surgery is not indicated at this time and surgeon manages conservative care.
- Pre-op: Surgery needed and a date may or may not be scheduled. If scheduled, it is in the future.
- Post-op: Surgery has occurred. You must have listed a surgery date in your case note.

THE STANDARD WORK CASE NOTE

The standard work case note is four narrative sections, including a list of the SHSC Standard Work categories.

- SHSC Activity: What SHSC activities were completed to move the claim forward? Who was spoken to? How were they contacted? What Standard Work pieces were identified?
- Barriers: What prevents the worker from recovering and/or the claim from moving forward?

- Worker Goal(s): Only apply if the SHSC spoke with the worker. Goals need to be SMART: Specific, Measurable, Attainable, Relevant, Time-based.
- Coordination Plan: What are the next steps the SHSC will take? Was a claim follow-up date set?

L&I is not asking for background in the SHSC case notes. Long narrative histories can distract the reader from important details. You may want to briefly summarize important information in your first case note. Only include this information in subsequent case notes if you find it helpful to complete your tasks as an SHSC.

TRANSITION TO YOUR CLINIC AND/OR SURGICAL CARE

SHSC activities begin with a worker referral to a surgeon in your clinic. This may come from your clinic appointment or surgery scheduler, a COHE HSC call and/or share or your surgeon becomes the AP.

SURGICAL COORDINATION INTAKE (SCI)

Because the SCI entails a comprehensive initial evaluation of a claim's status/history, it may only be billed once in the life of a claim. It's intended for workers coming in to see your clinic/surgeon for a consultation or treatment. You may only bill this code if your clinic has already agreed to see this worker. Make the most of this opportunity by reviewing and documenting important information. A well-performed SCI will involve many, but not all of the following features.

PERFORMING AN SCI

- Review L&I claim file in CAC and document things relevant to current consultation/treatment in your clinic:
  - Purpose for originating AP's referral to surgical clinic.
  - Current and prior treatment on this claim, including any surgeries, for the same body part (e.g. same arm, leg or adjacent major joint).
  - Diagnostic studies performed on this claim.
  - Concurrent care for same/other body parts/mental health.
    - Include name of concurrent care provider.
  - Ancillary care for same/other body parts (PT, OT, etc.).
  - Vocational reports (if applicable).
  - Most recent Independent Medical Exams (IME), if any.
- Document Red flags:
  - Treatment for same body part as this referral (including prior claims).
  - Opioid use concerns.
  - Non-compliance or non-cooperative behaviors.
  - Vocational reports (closing report and/or retraining plans).
  - Diagnostic studies for same body part as this referral.
  - Co-morbidities that must be considered before surgery (e.g. diabetes, heart condition, obesity, etc.).

- Review clinic's EMR for:
  - Prior treatment records, if any.[1]
  - Upcoming or new appointment dates and details including referrals (e.g. MRI or other diagnostic studies, etc.).

Lack of effective communication between all parties involved in the claim can cause delays in care transition, treatment, surgery authorization and the worker's recovery. Start communicating with all parties as early as possible to avoid delays that increase the worker's risk of long-term disability. Some SCI activities can prevent these delays and aid in recovery including:

- Contacting the referring provider to request records or diagnostic studies.
- Coordinating with a COHE Health Services Coordinator.
- Submitting a transfer-of-care request (through MAVEN) to the claims manager.
- Notifying ancillary care providers of the change in attending provider.
- Notifying the claim manager of an upcoming scheduled surgery date.

Finally, your SCI needs to include a care coordination plan. Because this is early in the worker's care at your clinic, the care plan may be contingent upon an upcoming appointment or diagnostic test. You should be thinking ahead to what you may need to do and who needs to be contacted for the most likely treatment recommendations.

CONSERVATIVE CARE STANDARD WORK

- Although an SHSC's main job is to assist workers who need surgical treatment, L&I's goal is for all workers to heal and return to work. You can and should assist workers referred to your clinic when:
- They aren't working and/or have no care coordinator assigned.
- Requested by any provider involved in the worker's care, including ancillary care and VRCs.
- Requested by the claim manager.
- When your coordination prevents employment loss or moves the worker to RTW and claim resolution.

All SHSC standard work applies to conservative care. For instance, a PFS helps assess the healing progress. RTW coordination is an important part of conservative care for those workers not yet released to their job of injury.

PRE-OPERATIVE (PRE-OP) STANDARD WORK

Pre-op standard work includes all the coordination activities you do up until surgery.

This table lists some tasks and examples along with links to department reference materials that may help you perform transition of care and pre-op standard work activities.

[1] *Referral for purposes not expected to result in care coordination don't qualify for this code (e.g. rating exam, worker who has been removed permanently from the workforce, etc.).*

	Transition to Your Clinic and/or Surgical Care (Pre-op Standard Work)
Tasks	**Examples**
Contact worker.	Direct contact with the worker is critical to providing care coordination services. Contact may be by phone or in-person (possibly adjacent to an appointment) as applicable. ***You must communicate with the worker in their preferred language.*** Find an interpreter at: **www.Lni.wa.gov/patient-care/treating-patients/interpreter-services/** 1) An initial introduction is important to setting the tone for communications that may last for several weeks. The worker should know: a) Your name and who you work for as well as how to contact you. b) How you help coordinate care and send information to L&I. c) How you can help them and how you can't (e.g. the claim manager makes decisions on your claim, etc). 2) Discuss how the worker can maximize their recovery potential by following treatment and RTW plans, keeping appointments and communicating concerns with physicians, CM, employer, VRC, and SHSC. 3) Conduct PFS and document responses in MAVEN. Important to note that you can transcribe responses from a PFS administered recently by your clinic. 4) Check-in with the worker about their goals for recovery and RTW plans. Fear of pain or re-injury can cause delays that may lead to long-term disability. ***Some discussion topics***: a) Overall, is your injury better or worse than you expected? b) Do you think you'll recover enough to return to your usual job? Why/why not? c) What concerns you about surgery? d) What has the doctor told you about your recovery from surgery? e) How do you feel about that timeline? f) What are your plans when you're able to return to work? g) Do you have any concerns about returning to work after your surgery? h) Is there anything your employer can do to help you transition back to work? i) Is there anything that I can do to help you plan your return to work? 5) Encourage workers to stay in contact with their employer throughout their treatment and recovery. Some possible discussion points: a) It's easier to return to your current employer than to find a new one. b) *Out of sight, out of mind.* Don't let them think you're not interested in returning. c) You might return to work with light duty or reduced hours. d) Release to work ends your time loss compensation whether or not you have a job. 6) If information comes out of phone conversation with the worker, then SHSC should notify the CM by phone, in your MAVEN Case Note or via a secure message through CAC.

Help remove barriers to surgery authorization when possible.	The surgeon and scheduler must meet L&I guidelines before requesting surgery. However in the case of a surgery denial, you may be able to help obtain information or facilitate a review of the surgery authorization request. Your first step is to determine the reason for surgery denial. **1)** If reason for denial was that department guidelines were not met, you can discuss surgeon's next steps and/or share the department guidelines with surgeon or clinic surgery scheduler: **www.Lni.wa.gov/patient-care/treating-patients/treatment-guidelines-and-resources/#treatment-guidelines** Another department resource for surgeon, surgery scheduler or you: **www.Lni.wa.gov/patient-care/authorizations-referrals/authorization/utilization-review** **2)** If CM denied surgery, review denial letter. Is there more information needed for surgery authorization? Contact the CM if you have questions then discuss with the surgeon and assist as needed.
Contact worker's employer	1. Verify current employment status, noting any red flags. 2. Confirm employer has copy of APF or describe the restrictions and send it to employer. 3. Offer to contact the surgeon with questions about the recovery plan or restrictions. 4. Get a copy of a documented job description, if not already in the claim file. 5. Ask if they have a modified duty program or if they're interested in developing one. **6.** Discuss the possibility of pre-op light duty when appropriate and the Stay-at-Work program. Stay-at-Work details can be found at: **www.Lni.wa.gov/claims/for-employers/employer-incentives/stay-at-work** 7. If there is a need for equipment or other resources, discuss the Early RTW Program.
QUICK TIPS	1) Remember that larger employers may have an established transitional work program. 2) Others may need help to developing these plans and may not understand the importance of early RTW. 3) They may use third party administrators (TPAs) to manage RTW or possibly assign it to human resources. Often the person responsible for RTW is NOT the worker's supervisor—you may have to search for that contact.
Communicate findings to surgeon.	The surgeon needs any information you have gained that may affect the recovery. 1) Identify red flags that may affect RTW and/or surgical outcomes to share with the surgeon. a) Long-term opioid use or chronic pain behavior or current use of street drugs or frequent change of AP — which may indicate a pattern of doctor-shopping and drug-seeking. b) Prior surgeries and/or frequent ER visits or intervening factors that impact recovery c) Mental health concerns. d) Other co-morbidities that must be addressed (e.g. obesity, smoking, etc.). e) Multiple claims and injuries since the first time claim was established. f) Non-cooperation. 2) Depending on your setting, you may be able to add this to the EMR or speak with the surgeon. Alternatively, you might have to print and fax a copy of your case note or other agreed upon notification to your surgeons at another location.

Assist Surgeon with RTW Plan.	Before the scheduled pre-op office visit: 1) Provide information specific to the worker that you obtained in your review or discussion with the worker or employer to help surgeon develop a RTW plan. a) Offer appropriate suggestions, (e.g. does employer's light duty job offer fit restrictions or does worker seem to have a fear of re-injury?). b) Include the job description if you have one and ensure the surgeon is prepared to establish RTW plans and goals with the worker at the pre-op appointment. 2) Repeat these if worker's restrictions or employer's light duty work options change.
Documenting your work in MAVEN:	1) Make sure you have updated the correct surgical phase (consultation, conservative care, pre-op, post-op). 2) Case notes communicate what you have done and your next steps to others working on the claim. 3) Remember to use buttons to indicate everyone you contacted. 4) If planning follow-up, you may need to set a task. You can't bill for services unless you create a case note. *Don't work for free*!

BARRIERS ASSESSMENT

A barrier is anything that may prevent the worker from healing and/or returning to work. It's important to identify barriers and communicate them to the surgeon, AP, VRC or CM, as appropriate. A few examples of barriers:

Barrier:	**May affect:**	**Communicate with:**
Delays in claim allowance, approval of a diagnostic test; acceptance of a condition; change in AP.	Timely treatment and continuity of care.	Surgeon, CM.
Recurrent injury/surgery to same area.	Release to the job of injury.	CM, VRC.
A co-morbidity such as smoking, obesity, a medical condition such as diabetes, etc. that can be addressed to aid recovery.	Recovery or prevent surgery.	CM – temporary treatment.
Frequent requests for pain medications.	Recovery, ability to control pain after surgery (if on pain medication before surgery).	Surgeon.
Medical information indicates worker may not be able to return to the job of injury and there is no VRC assigned.	Return to work.	CM to assign a VRC.
Missed appointments, worker failure to follow treatment instructions.	Recovery and return to work.	Surgeon, CM, ancillary care providers.

BARRIERS ASSESSMENT TOOL – THE PAIN AND FUNCTION SCALES (PFS)

SHSC standard work includes administering PFS and documenting them in MAVEN.

1. Until pain plateaus at a mild level, document PFS values using the Tool for Assessing Pain and Function, 4c below. Conduct PFS as often as necessary, and at a minimum:
   a. Pre-operatively (e.g. if a planned surgery determine whether not urgent or emergent).
   b. An initial post-op call.

c. At six weeks post-op.

d. Every three months thereafter for so long as the SHSC keeps the intervention open.

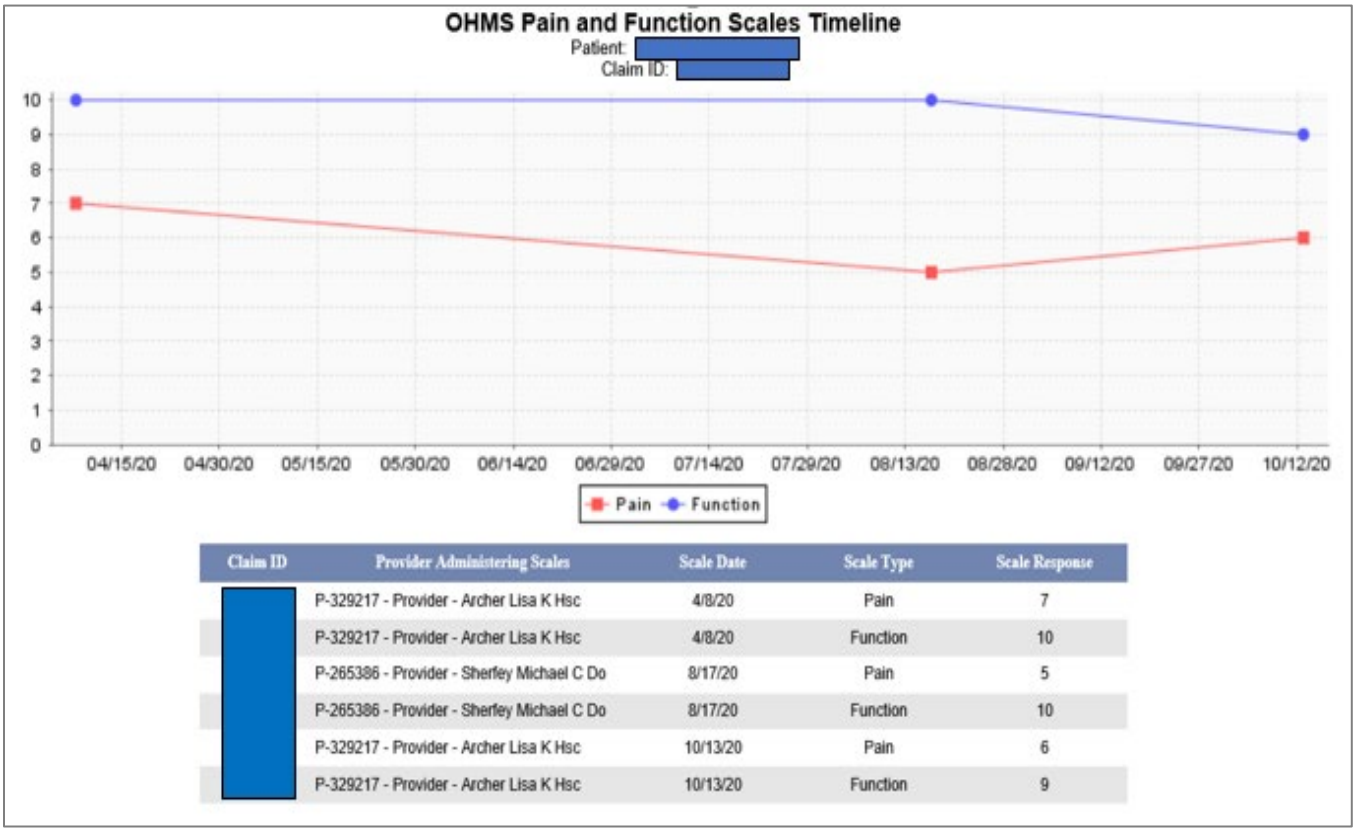
2. Method of administering the PFS include a phone call to the worker or transcribing clinic chart notes. If clinic chart notes only list pain score, you should still document this score in OHMS.

   a. "I'd like to ask a couple questions, to help your providers understand your recovery."

   b. "We expect pain to decrease and function should increase, post-surgery. How's yours, now?"

THE PFS TIMELINE

1. Comparison of pain and function scores can be diagnostic, depending on where the worker is in their recovery. Pain score may be high and function low before surgery and for the immediate post-op period (up to two weeks). After that, we expect pain and interference with activities to decrease.
2. The scales timeline can be a useful tool to share with the surgeon when pain intensity increases or plateaus without increase of functionality as in this example.



Claim ID	Provider Administering Scales	Scale Date	Scale Type	Scale Response
[redacted]	P-329217 - Provider - Archer Lisa K Hsc	4/8/20	Pain	7
	P-329217 - Provider - Archer Lisa K Hsc	4/8/20	Function	10
	P-265386 - Provider - Sherfey Michael C Do	8/17/20	Pain	5
	P-265386 - Provider - Sherfey Michael C Do	8/17/20	Function	10
	P-329217 - Provider - Archer Lisa K Hsc	10/13/20	Pain	6
	P-329217 - Provider - Archer Lisa K Hsc	10/13/20	Function	9

3. Compare changes in pain or function values to the clinical notes – there may be a medical cause (e.g. hardware removal surgery may result in increased pain).
4. Share a copy of the pain and function timeline with the provider when you believe worker scores are "going the wrong way" after the immediate acute (conservative care) or post-op period:

   a. If both pain and interference in function goes up, without a medical reason (e.g. PT/OT initiated).

   b. Pain and function plateau at 4-5 or above (without medical reason like infection, another surgery) there could be a problem and should probably share the scale with the surgeon/PAC.

c. See cut-out attached, taken from Appendix C, Page 30, of the on-line Opioid Treatment Guidelines (see **www.Lni.wa.gov/patient-care/treating-patients/drugs-and-prescriptions/prescribing-opioids-to-treat-pain-in-injured-workers**).

Two Item Graded Chronic Pain Scale

Graded chronic pain scale: a two-item tool to assess pain intensity and pain interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [*That is, your usual pain at times you were in pain.*]

No pain										**Pain as bad as could be**
0	1	2	3	4	5	6	7	8	9	10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities."

No interference										**Unable to carry on any activities**
0	1	2	3	4	5	6	7	8	9	10

Interpretation of the Two Item Graded Chronic Pain Scale – This two item version of the Graded Chronic Pain Scale is intended for brief and simple assessment of pain severity in primary care settings. Based on prior research, the interpretation of scores on these items is as follows:

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1–4	5–6	7–10
Pain-related interference with activities	1–3	4–6	7–10

Although pain intensity and pain-related interference with activities are highly correlated and tend to change together, it is recommended that change over time be tracked for pain intensity and pain-related interference with activities separately when using these two items.

For an individual patient, a reduction in pain intensity and improvement in pain-related interference with activities of two points is considered moderate but clinically significant improvement.

POST-OPERATIVE (POST-OP) STANDARD WORK

We expect SHSC standard work and coordination plans to include review actions every four to six weeks until the worker reaches maximum medical improvement (MMI) from the condition(s) treated by your surgeons. Once the worker has returned to some type of employment, less frequent review and actions may be appropriate on some claims.

Some types of post-op standard work may include:

- Reviewing the claim file in CAC for activity since your last review (at least).
- Administering PFS and clinical referral coordination/tracking.
- Ongoing monitoring and/or communicating medication issues to the surgeon.
- Providing community services referrals (as needed and available).
- Checking RTW estimate – is it approaching?
  - Surgeon should have discussed RTW with the worker at a pre-op appointment.
  - The RTW discussion should occur as soon as possible, if the surgery was emergent or urgent – or if it just didn't occur pre-operatively.
  - Remind the surgeon of the need to have this RTW discussion and assist with job descriptions or other information provided by the employer.
- When it appears that the worker won't achieve the surgeon's previously estimated RTW date for any kind of work, request the surgeon to consider a new RTW plan.
- Preparing the surgeon to adjust RTW plans if something changed with the worker, employer or VRC.

COMMUNICATING MEDICATION ISSUES

Ensuring that a worker is taking their medication as their AP prescribed is another key factor in ensuring the successful outcome of a claim. The SHSC should communicate to the injured worker's AP if they find a worker isn't taking their medication as prescribed, complains of pain issues or shows drug-seeking behaviors.

SHSCs should only make APs aware of medication problems and not get into a debate with either the worker or AP.

CLINICAL REFERRAL COORDINATION AND TRACKING

Your clinic may have someone assigned who facilitates referrals to ancillary care providers. Don't duplicate this activity. Your responsibilities include:

- Tracking referrals the surgeon has made to PT/OT, behavioral medicine or other providers.
- Following up with the worker to ensure they have engaged with referred services.
- Checking in with the worker to identify barriers and helping them plan to resolve them.
- Reviewing progress reports sent to the surgeon:
  - Document issues such as patterns of missed appointments, poor effort, etc.
  - Note any recommended follow-up diagnostics.
  - Bring issues to the surgeons' attention and discuss any clinic visit notes to determine next steps.

DOCUMENTING THE PHYSICAL MEDICINE PROGRESS REPORT (PMPR) IN MAVEN

PT/OT providers are required to send progress reports to referring providers on the PMPR form. Surgeons or their PA must review, sign and return the PMPR to the PT/OT with 14 days. We measure them on this activity based on you documenting their signature date on your case note in MAVEN. Don't let it slip, as failure to document this signature in a timely manner may cost the surgeon money.

ASSISTING WORKERS WHO AREN'T MEETING POST-OP GOALS

A small percentage of workers don't meet recovery and/or release to work goals. A medical reason for lack of progress may or may not be readily apparent. Your post-op standard work is to find and help this small percentage of workers before long-term disability issues develop. You might say they're the most important workers on your caseload. Some flags might include:

a. The surgeon's APF indicates workers progress as "slower than expected."
b. Worker's pain and function experience has not matched healing/rehab expectations.
c. Other SHSC noted indicators (PT/OT notes indicate not putting forth full effort or pain reactions, early calls to refill pain meds, etc.).

This series of tasks and examples represents actions found in your traditional Post-Op Standard Work activities along with suggestions for when workers aren't meeting the post-op goals.

Post-Op Standard Work

Tasks	Examples
Post-op follow-up to check progress. **Consider scheduling a review after the first post-op visit.**	1. Review post-op report and rehab plan, and document any issues that come up. 2. Contact the worker as often as needed for things like PFS. Possible questions include: a. If in therapy, how is your recovery and rehabilitation progressing? b. Overall, is your injury better or worse than you expected it to be at this point? c. Taking into account your post-op recovery, do you think that it will get better soon, slowly, never get better, get worse, or result in a full recovery? d. How long do you think it will take to return to your usual activities? 3. Reinforce the rehab and RTW plans and goals. Possible questions: a. When do you think the doctor will release you to return to work? b. When did you last speak to your employer and what was discussed? c. What are your concerns about returning to work? 4. Make sure to advise the surgeon of any issues or red flags. 5. Schedule follow-up reviews and contacts with the worker and others, as needed.
Assist surgeon in setting RTW plan. **Before the next scheduled office visit, follow these steps.**	1. Check your coordination plan for dates or activities related to RTW. 2. Contact the employer about RTW at any level. Encourage the employer to think of light duty tasks the worker might perform even if no full-time light duty job is available. 3. Possibly recommend PT/OT, depending on where worker is in treatment and PMPR notes. 4. Provide specific details to the worker to help the surgeon develop a RTW plan. 5. Provide suggestions where appropriate, like if the employer's light duty job fit restrictions or if the worker seems to have a fear of re-injury.
Contact the worker before and/or after office visits. **Review your care coordination plan to know when to contact the worker.**	***Before*** the office visit, you may need to contact the worker if: 1. You have pre-visit follow-up with the worker listed in your care coordination plan. 2. PFS is due. Post-op PFS due dates are listed in the heading section of your case note and on the Post-Op Work List. 3. You need to ask about something you found in your pre-visit review of CAC or your EMR. a. Previous "no-show" for appointments b. Poor cooperation or "no-show" to PT/OT or other ancillary provider ***After*** the office visit, you may need to contact the worker to: 1. Review the APF for RTW "Estimate what the worker can do" and "Capacities" sections. 2. Conduct a follow-up phone call to the worker. Options include: a. Use the RTW plan and the APF to emphasize the importance of mobilizing progressively and staying active, discussing RTW/ERTW plans with their employer, or assigned VRC. b. Refer to the treatment plan to discuss recovery progress, goal setting, following doctor instructions and medication management. c. Assign the worker a date to contact you to report progress towards goals.
Communicating the RTW plan	Communicate RTW plans documented by the surgeon and discuss possibility of modified or light duty with the employer, CM, and VRC (if applicable).

Assist workers who aren't meeting post-op recovery and/or release to work goals.	1. Identify workers not on track to reach post-op RTW goals. Indicators may include: a. Surgeon's APF indicates workers progress as "slower than expected." b. Worker's pain and function experience has not matched healing/rehab expectations. 2. Contact the surgeon for an informal case conference: a. Surgeon may consider whether modifications in the rehab plan would be effective. b. Surgeon may consider transferring care to Occupational Medicine or referring AP for focused follow-up. c. You may consider other options, like activity coaching, smoking cessation, etc.
Arrange a collaborative team conference.	Although not a frequent occurrence, you may need to suggest or set up a team conference for your surgeon with other of the worker's ancillary care providers. 1. Coordinate a collaborative team conference (by phone or in-person) to re-evaluate rehabilitation and RTW plans as soon as appropriate. a. A case conference template is located in the appendices b. Conference may occur in person or by phone 2. Always invite the referring AP unless the worker was originally referred by an ED or the AP won't be taking the worker back into their practice when released from surgeon's care 3. Invite other care team members (e.g., PT/OT, behavioral health, etc.). 4. Discuss the option of activity coaching. Information about activity coaching is available at:**www.Lni.wa.gov/claims/for-vocational-providers/transitioning-back-to-work/activity-coaching**
Documenting your work in MAVEN:	1. Make sure you have updated the correct surgical phase (consultation, conservative care, pre-op, post-op). 2. Case notes communicate what you have done and your next steps to others working on the claim. 3. Remember to use radio buttons to indicate everyone you contacted. 4. If planning follow-up, you may need to set a task.

WORKING WITH THE VRC

- If the CM assigns a VRC, they get the first opportunity at return to work services.
  - You should still follow the worker's medical progress.
  - You should still call the worker to discuss their medical care. It's okay to ask them about goals and how they're feeling about returning to work.
  - Identify any recovery barriers and notify the surgeon before the worker's next clinic visit so that the surgeon can address them. Recovery barriers might include thing such as:
  - Increased pain complaints.
  - Concerns about their restrictions.
  - Problems listed in PT/OT notes.
- Communicate with the VRC any changes in the worker's treatment or condition (e.g. post-op infection, new surgery, etc.).
- Ensure the surgeon reviews, signs and returns documents to the VRC such as job analysis (JA) for the job of injury and/or other work needing the surgeon's approval.

FINISHING-UP TREATMENT IN THE SURGICAL CLINIC

During a six-year pilot, surgeons agreed that for most uncomplicated surgeries, workers can be safely transitioned to non-surgical care at about 150 to 180 days post op.[2] This may help surgeons open up their schedule for other workers and for non-L&I patients. Keep in mind that it's always up to the surgeon when it's appropriate to transition a worker to another provider.

This table includes some tasks and examples that may help you perform post-op standard work activities.[3] These brief descriptions and examples represent the average post-op course.

Assisting Surgeon With Finishing Touches

Tasks	Examples
Track post-op days in MAVEN **Discuss plans with surgeon**	MAVEN displays post-op days counted from the most recent surgery date. You'll find this count in the case note header and on the post-op list. 1) The SHSC should look for the following indications at about 120 days post-op for uncomplicated surgeries or 150 days for surgeries on Extended Recovery Surgeries: a) Worker is approaching MMI and surgeon plans to rate PPD (themselves or in the clinic) or request the CM to schedule an IME. b) Surgeon will transition worker back to the referring provider or a new AP. **c)** Another surgery is probable or scheduled. 2) If none of the above activities are mentioned, consider approaching surgeon to ask: a) Is there anything left to do? b) Can the original AP or an occupational medicine clinic finish the treatment plan? c) Can I assist with transition or final activities? 3) If the surgeon decides they will continue to treat, you should continue to work on the claim until the worker reaches MMI. Set your task/reviews for on-going monitoring at whatever interval you deem appropriate.

Again, remember to document your work in MAVEN

TRANSITION OF CARE AWAY FROM YOUR CLINIC TO ANOTHER PROVIDER:

Most often, the worker will know to whom they're transferring to once they have completed care in your clinic. On occasion, the worker or the surgeon may ask you to assist with transitioning the worker to another provider. This is more likely to occur if the worker came to your clinic from an Emergency Department.

[2] *See Extended Recovery Surgeries at Appendix 2.*

[3] *Note that some topics such as return to work may appear in several examples.*

Standard Work for Transitioning to New Provider	
Tasks	**Examples**
Prepare to transition the worker to the next step in appropriate care.	At approximately 150 to 180 days post-op, the surgeon may plan to transition the worker to a non-surgical AP for care. Your post-op list has a prompt for you to discuss transition with the surgeon set at 120 days post-op. Follow the OHMS manual if you need to change this date. If the worker is MMI or has already transitioned to another AP: 1) Update the medical records in CAC (especially operatory). 2) Close your intervention with a case note, also notifying the CM.
Helping the worker find a new AP if they have none.	1) You can assist with transitions if requested by the worker or the surgeon. Transition may be back to the original referral AP or to a new AP when referring provider is not an option. 2) Understand the worker's expectations regarding level of assistance you'll provide. This may be as simple as pointing the worker to Find-A-Doc. 3) **https://lni.wa.gov/claims/for-workers/find-a-doctor/** 4) Consider contacting the COHE HSC to discuss providers who are accepting new patients. 5) When appropriate, share RTW plan and most recent APF with the gaining AP/HSC. 6) Help make initial appointment, if needed, within seven business days of referral. 7) If not yet done, transmit compiled information to the next AP. 8) Set up a case conference if requested by either the surgeon or the AP.
Closing transaction with the worker.	Contact worker by phone to explain what to expect in next phase of care and reinforce message about what worker can do to impact positive outcomes, including: Follow plans, progress mobility, keep appointments and report complications.
Documenting your work MAVEN	1. Document the surgeon's transition plan for worker, whether or not you're assisting with that transition. 2. You need to follow-up with the surgeon on a transition date. o Using a task and in-process note for this purpose may be an alternative to a case note. 3. Document your efforts to assist the worker in finding a new AP. 4. Close the intervention if the transition or rating has already occurred. 5. If the transition or rating is in the future, consider creating a watch date or a task to follow-up. Finalize transition to the new provider.

COMMUNITY SERVICES REFERRALS

Since you'll be having regular contact with workers, you may hear of difficulties they're having that interfere with their healing. We don't expect you to solve these problems! Be prepared to share community resources that can help with housing, food, transportation, childcare or other services. You may already have a list of resources available in your community at your clinic or be able to attain them from hospital discharge services, COHE HSC, on the web or from a local place of worship.

MAXIMUM MEDICAL IMPROVEMENT (MMI)

Notify the CM when the worker is approaching or has reached MMI from the condition for which your surgeon is treating. Based on the surgeons' next steps, if requesting an Independent Medical Exam (IME) you might:

- Close the intervention, with or without a watch date.
- Perform transition standard work and then close the intervention and take other steps, as appropriate.

Attorney Involvement

When a COHE sponsors an SHSC, the SHSCs shall follow the guidelines established by the sponsoring organization that governs this activity. If no such sponsorship or policy exists, the SHSC should contact the workers represented by an attorney directly, unless specifically asked not to by the worker or their attorney. When an SHSC engages in a discussion with an attorney, their participation should be mindful of, and consistent with, their role as an extension of the treating doctor.

Non-English Speaking Workers

L&I's provides limited English proficient (LEP) customers timely and meaningful access to all agency programs and activities. You represent L&I for the worker—and are expected to adhere to the same guidelines that define L&I staff interaction with our customers. In the case of interpreter services, this includes the October 2015 U.S. Departments of Justice and Labor and WA L&I agreement to improve access for LEP workers.

Undetermined Claims

A CM may not be able to make a decision to allow a newly filed claim. Until to the claim is allowed or rejected, it's in Undetermined Status. Please work these claims if needed, as the workers still need services. Once allowed, the appropriately billed for services are paid (about 35% of claims are rejected).

Surgical Health Services Coordination Qualitative Assurance (QA) Review Process

L&I will conduct quantitative and qualitative QA reviews as outlined in this manual. Though these may include processes that are unique to the clinic or organization in which you work, we recommend that SHSC supervisors and represented clinics also conduct QA reviews. After all, an SHSC's work directly affects a surgeons' performance score.

FREQUENCY AND DURATION OF L&I QA REPORTS

- For the first year of a person becoming an SHSC, L&I contract managers will:
  - Review two claims each month for the first three months.
  - If they pass the monthly reviews, the reviews would go to quarterly.
    - Review two claims every quarter for the reminder of the 12-month period.
- If they pass the first year reviews, they move to an annual review cycle on the anniversary of their last review.
- The L&I contract manager should provide the QA review report to the care coordinator and/or their supervisor before the formal review discussion, allowing them to conduct their own review.
- The L&I contract manager will share these reviews with the appropriate audience, including the SHSC, their supervisor and another person(s) selected to participate in the conversation by either the care coordinator or their supervisor.
- As a result of this discussion, the following things may happen:
  - An L&I contract manager may ask the care coordinator to provide corrective responses in non-billable supplemental case note(s).
    - Timeliness is a significant consideration as outlined in MARFS Chapter 2.
    - Furthermore, the Medical Aid Rules and Fee Schedule (MARFS), Chapter 2 makes it possible to recoup payment(s) should the SHSC repeatedly show poor documentation and failure to respond to feedback from the L&I contract manager.

Resources

Occupational Health Management System (OHMS)

SHSCs are required to use OHMS. The link to the Surgical User's Guide is located in the bottom right hand corner of your OHMS Home Page.

Interpreter Services

If you call an injured worker who can't speak English and the claim has been allowed, you may need to access telephone interpretations services. L&I's process for paying for these services has recently changed and further updates are expected. It's advisable to refer to the L&I web page with information about the telephone interpretation. Interpretive services can only be used on allowed claims:
www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/Interpreters/codes

Health Information Portability and Accountability Act (HIPAA)

It's important for all SHSCs to be sensitive to claim and health information levels of confidentiality. The Health Insurance Portability and Accountability Act (HIPAA) requires the health care industry to protect the security of stored health care records and those transmitted electronically. HIPAA exempts workers' compensation programs from the Act's Privacy Rule authorization requirement (45 CFR § 164.512(l)). Claims information has its own set of legal requirements that take precedence over HIPAA regulations. (Insert link to RCW site for Title 51) HIPAA allows exceptions for workers' compensation claims. HIPAA's "minimum necessary" standard doesn't apply to workers' compensation or crime victims' compensation claims.

You may disclose personal health information to the department without an authorization from the worker, and without violating HIPAA, as long as it's related to the industrial injury. In addition, L&I's HIPAA exemption allows you to disclose personal health information regarding work-related illnesses or injuries directly to the employer of record, injured worker and attending provider without an authorization. This means that you can release information about the worker's physical restrictions to an employer who may have light-duty work available. For more information on HIPAA, refer to the following link on L&I's web site:
www.Lni.wa.gov/ClaimsIns/Providers/Claims/HIPAA.

The SHSC needs permission from the worker to talk with a new employer about restrictions related to an injury occurring while the worker worked elsewhere.

If a worker is a member of a union and he or she wants you to work with their union representative(s), then you can share information with the union about the claim. The union can be a valuable resource for early and appropriate return to work.

You're able to send secure messages and attachments to claim managers through OHMS. Due to HIPAA regulations, please don't send claim numbers or social security numbers attached to unsecure e-mail. Many medical offices subscribe to secure e-mail services. Contact your information technology representative to discuss whether you have access to send secure e-mail service.

L&I has secure e-mail. When you receive a secure e-mail from L&I (outside of OHMS) for the first time, it will include a link to create a secure password.

It's important to remember that you're viewing, discussing, and handling health care and claim information. You should keep this information secure at your desk location, transmit information through secure lines only, and take care to use secured technology when working with claim-specific information.

OTHER SHSCS ARE AN IMPORTANT RESOURCE. CALL THEM IF:

- You have claim specific question (an injured worker has transferred from them).
- If you have questions about how other SHSC s are operationalizing a best practice, improving a process, or identifying a process issue.
- You have ideas about improving any aspect of SHSC work you want to discuss.

L&I PUBLIC WEB RESOURCES

- L&I Home Page: **www.Lni.wa.gov/**
- Employer's Resources: **www.Lni.wa.gov/claims/for-employers/injured-worker-what-you-need-to-know/**
- Employer's Return-to-Work Information: **www.Lni.wa.gov/claims/for-employers/help-your-employee-return-to-work**
- Find-a-Doctor: **www.Lni.wa.gov/claims/for-workers/find-a-doctor/**
- Workers: **www.Lni.wa.gov/for-workers**
  - **www.Lni.wa.gov/claims/for-workers/injured-what-you-need-to-know/**
- Medical Treatment Guidelines: **www.Lni.wa.gov/patient-care/treating-patients/treatment-guidelines-and-resources/#treatment-guidelines**
- Opioid Prescribing Guidelines: **www.Lni.wa.gov/patient-care/treating-patients/drugs-and-prescriptions/prescribing-opioids-to-treat-pain-in-injured-workers**
- Ortho/Neuro Surgeon Quality Project: **www.Lni.wa.gov/patient-care/provider-partnership-best-practices/orthopedic-and-neurological-surgeon-quality-project**

CONTACT INFORMATION

SQC Program Help Desk	(360) 902-6060 or email SQCProgram@Lni.wa.gov
OHMS Help Desk	(360) 902-4259 or (360) 902-6533 or email **OHMSHELP@Lni.wa.gov**
Fax to Claim File:	(360) 902-4567

APPENDICES:

1. Health Services Coordination Activities Billing Status Key

Best Practice Program	Activity	Billing Status
All	Initial review of the claim (ROA, APF, CAC, RLOG, View Documents, etc.)	Bundled in the fee
All	Follow up review of the claim (updates, changes, care coordination plan, orienting to the details of the claim again)	Bundled in the fee
All	Documenting a health services coordination case note.	Bundled in the fee
All	Building/determining a care coordination plan (assessing needs, analysis of next steps, establishing patient goals and desired outcomes, tracking goal progression/regression).	Billable
All	Communicating with any party on the claim (providers, employers/TPAs, L&I partners, and workers/rep).	Billable
All	Being part of a case conference	Billable
All	Arranging a case conference	Billable
All	Conducting a peer staffing	Billable
COHE	Assisting/Preparing a COHE Advisor with reviewing a claim	Billable
All	Working to find resources for a patient	Billable
All	Working with another care coordinator	Billable
All	Working to assist a patient in transition of care	Billable
All	Completing a transfer of care document for the provider	Billable
All	Helping the provider determine next steps (ex: what's needed for pre-authorization, occupational disease paperwork, protesting claim decisions, communicating with a claim manager, opioid paperwork, etc.)	Billable
All	Correcting claim information at L&I (ex: patient name)	Billable
All	Follow up on a task requested by a claim manager or other L&I staff (ex: ONC)	Billable
All	Completing pain/function scales in OHMS	Billable
COHE/Top Tier	Completing FRQ scale in OHMS	Billable
All	Gathering information at the request of the provider	Billable
All	Travel to and from the work site	Not Billable
COHE/Surgical	Conduct a provider orientation/education	Not Billable
All	Answering a provider's questions about best practice reporting	Not Billable
COHE	Discussing a specific provider with the Medical Director	Not Billable
All	L&I approved/requested L&I Training / Conferences	Billable through other means (A-19)

2. Care Coordination Standard Work Reference Card

- Coordination of surgical care
    - Ensure communication to workers who are surgical candidates.
    - Ensure that worker has pre-operative released-to-work plan.
    - Engage with the worker and monitor their post-operative recovery and released-to-work plan.
    - Communicate with surgeon when the worker is not making progress on their post-operative

recovery and released-to-work plan.
    - Assist the workers in transitions to a non-surgical provider when appropriate.
- Coordination and tracking of referrals
    - Track referrals through provider chart notes and follow-up with worker to ensure that they have engaged with referred services.
    - Contact referred providers' offices as needed.
    - Check with worker to see if there are any barriers to completing referred services and work to resolve them.
    - Check with provider chart notes to determine next steps.
- Assessment of barriers to recovery
    - Document pain and function scales to ensure that progress is being made. Alert attending provider if pain and function scales show that progress is not being made.
    - Complete other assessments (ex: barriers assessment).
- Ongoing monitoring of recovery
    - Review new patients, work lists, and tasks daily.
    - Assist workers in navigating L&I and health care systems.
    - Determine and follow up on care coordination plan goals and next steps.
    - Coordinate case conferences and suggest PGAP or other programs.
    - Assist providers and workers in completing occupational disease or opioid paperwork.
- Referral to community services
    - Maintain a list of community resources and share them with worker as needed.
    - Follow up with workers about community resources if it is part of their care coordination plan.
- Assistance with medication issues
    - Explain the new prescribing best practices to providers (L&I resources and guidelines).
    - Check with patients about their medication usage and if they're taking them as prescribed. Report issues to providers.
    - Alert provider if the patient complains of pain issues and/or shows drug-seeking behaviors. Discuss referrals to possible interventions (ex: Progressive Goal Attainment Program) with the provider.
    - Remind providers about L&I opioid paperwork and requirements.
- Coordination of return to work
    - Ensure that employer, provider, and worker understand restrictions/capacities, RTW expectations, programs, and assistance opportunities (ex: WSAW).
    - Answer questions about L&I related programs.
    - Assist employers with job descriptions; assist VRCs with working with providers in completing the job analyses process.
    - Communicate and coordinate with VRCs.
    - Track worker's work status and include return to work goals in the care coordination plan as needed.
- Support during transitions of care

- Assist the worker in finding a new attending provider when needed.
- Assist provider in submitting transfers of care when needed.
- Provide continuity of care for workers coming from emergency departments and needing ongoing care.
- Assist workers transitioning to and from attending provider care.
- Communicate with other health services coordinators when workers are transitioning to other providers.

3. Extended Recovery Surgeries

Appendix 3 **Extended Recovery Surgeries** **As of 1/29/20**

Surgery Type[1]	CPT	Expected Improvement in Pain & Function	Safe Transition of Care (e.g. Occ Med or referring provider)[2]	Comments / Factors to Consider
Shoulders / Knees				
Open Rotator Cuff Reconstruction +/- Distal Clavicle Excision	23420/23120	4-6 months	150 – 180 days if not progressing	Active PT may not start for 3 months
Open Repair Complete rotator cuff	23410/23412	4-6 months	150 – 180 days if not progressing	Active PT may not start for 3 months
Decompression subacromial space with partial Acromioplasty and Arthroscopic cuff repair	29826/29827	4-6 months	150 – 180 days if not progressing	Active PT may not start for 3 months
Anterior Cruciate Ligament (ACL) Repair PCL Reconstruction	29888/29889	4-6 months	150 – 180 days if not progressing	Graft maturation known to take > 6 months to occur
Total Joint Arthroplasties				
Total Shoulder / Reverse Total Shoulder Arthroplasty or Hemi-arthroplasty	23470/23472	4-6 months	150-180 if not progressing	Active PT may not start for 3 months
Total Knee Arthroplasty	27447	4-6 months	150 – 180 days if not progressing	Motion/Strength can often improve for > 6 months
Total Hip Arthroplasty	27130	3-4 months	150 – 180 days if not progressing	Function can often take 3-4 months to improve
Spinal Fusions				
Cervical Fusion	22554	3-4 months	150 – 180 days if not progressing	Function can often take 3-4 months to improve
Lumbar Fusion	22558	4-6 months	150 – 180 days if not progressing	Improvement in function and final fusion can often take 4-6 months to occur

[1] For uncomplicated course of recovery
[2] If greater than 150 days post-op

Source: Drs. F. Huang & E. Novak; Validated by Pilot Medical Directors

4. Case Conference Note Template

Patient Name/DOB:				
MRN/Claim No:				
DOI:				
Employer:				
Accepted Conditions:				
Purpose of Staffing:				
Staffing Meeting Date:				
Team Members Present:				
Time Spent:				
Status Update:				
Treatment Goal:				
Barriers:				
Actions to be taken	Responsible Team Member(s)	Due Date	Request SHSC follow-up	Due Date
Next Checkpoint Date if indicated: _____ Provider Signature		_____ Date		
Upon completion of the meeting, please follow these steps: ☐ Attending Provider or Surgeon completing conference note bills 99367. ☐ Signing provider Faxes form and any applicable chart notes to L&I at 360-902-4567 ☐ Upload conference form into EMR				

5. Blank SHSC supplemental to provider application

STATE OF WASHINGTON
DEPARTMENT OF LABOR AND INDUSTRIES
INSURANCE SERVICES — HEALTH SERVICES ANALYSIS
PO Box 44261 • Olympia Washington 98504-4261

Dear applicant,

Thank you for your interest in working with surgeons participating in the Washington State Department of Labor & Industries' Surgical Quality Care Program. In order to be of service to participating surgeons, you must complete the Supplemental Provider Application.

This application in and of itself does not grant you access to the Department of Labor and Industries Occupational Health Management System (OHMS), which is an essential tool for completing your work as a Surgical Health Services Coordinator. To gain that access, you must seek and establish relationships with participating surgeons who will then enroll you in OHMS. Termination of your relationship with a surgeon and/or their clinic will have no impact on your L&I Provider ID or your relationship with other surgeons / clinics.

To learn more of the scope of this program, eligibility and participation information, please refer to the **Surgical Health Services Coordinator's Manual**.

Sincerely,

Provider Accounts

Washington State Department of Labor & Industries

A Surgical Health Service Coordinator's Supplemental Provider Application for the Surgical Quality Care Program

Send Completed Supplemental Provider Application to

Occupational Health Services via Email to: SQCProgram@LNI.WA.GOV

As a Surgical Health Services Coordinator (SHSC), you will be providing services to injured workers and supporting their treating surgeons who are participants in the Washington Department of Labor and Industries' (L&I) Surgical Quality Care Program (SQCP). These support services are defined in the SHSC Manual, and this SHSC Manual is incorporated by reference.

The SQCP utilizes a tiered payment system, linking a surgeon's incentive fee payment level to how strongly they, or their group, implement specific occupational health best practices as defined in the SQCP manual (SQC Manual). Some of these occupational health best practices require SHSC services and a portion of those services are billable to the Department of Labor and Industries (L&I) or Self-Insured Employers (collectively referred to as "the payors").

SQCP aims at improving health-care services and access to surgical care for injured workers. The program's goal is to improve quality of care through a collaboration between the payors and the participating surgeons, with the desired outcome of improved processes and reduced administrative burden. Your work as an SHSC makes this obtainable by coordinating with all the parties to a claim.

To become an SHSC, submit a signed Supplemental Provider Application to L&I, along with all required supporting information. By submitting these materials, you acknowledge that you, the SHSC(s) applicant:

- Work in Washington or in a neighboring community of Oregon or Idaho, and have a fully accepted individual L&I provider identification number, and
- Have completed the on-line orientation for the Surgical Health Services Coordinator, and
- Will perform Care Coordination Standard Work as outlined in the SHSC Manual.
- Will manage and document your work using L&I's web-based Occupational Health Management System (OHMS).
- Will protect all injured worker personal information (IWPI) accessed, collected, used or acquired through L&I, SQCP surgeon(s), or alternate resources.
- Agree to not release, divulge, publish, transfer, sell or otherwise make IWPI known to unauthorized person(s).
- Agree to use IWPI solely for accomplishing care coordination standard work services as defined in the SHSC Manual to improve injured worker outcomes.
- Take due care to protect all data from unauthorized physical and electronic access and ensure compliance with all appropriate federal laws and applicable provisions of Washington State Law.

SHSCs may use the following billing code, which is reviewed annually, and published on the Medical Aid Rules and Fee Schedules (MARFS) webpage.

- The Surgical Health Services Coordinators' billing units – 1088M

Use of the MARFS billing codes constitutes acceptance of the payment policies and requirements as defined in the SHSC Manual, as well as the MARFS policies. Association with a surgeon that participates in the SQCP will not guarantee that the payors will pay all billed for services. The payors will purchase only covered services, provided by covered professionals. **L&I's General Provider Billing Manual** addresses billing matters for State Fund claims and it is updated annually. All matters concerning self-insured payments and/or denials are to be addressed with the applicable payor on a case-by-case basis.

We expect SHSCs to show improved compliance with the Care Coordinator Standard Work over time. This leads to continuous improvement in the care process. These expectations and measurement details are published in the SHSC Manual. If you still have questions after reviewing the SHSC Manual, you may contact the SQCP team at SQCProgram@LNI.WA.GOV.

You are held to the terms of this supplemental provider application and the SHSC Manual, even if a third party may be involved in billing claims to the payors. L&I reserves the right to deny, revoke, suspend, or condition your authorization to serve as a SHSC immediately, effective on the date of the notice of non-compliance with the terms of this supplemental provider application.

Either L&I or you may terminate this application at any time by submitting a notice of termination in writing. The termination is effective on the date of the notice, or mutually agreed upon date.

Provider's Statement of Agreement

I, _____, agree to abide by the terms of

Print Name Clearly

this Supplemental Provider Application, the program guidelines as outlined within the Surgical Health Services Coordinator manual, and all applicable federal and Washington State statues, rules, and policies.

Provider Number	Tax Identification Number	
Group / COHE Name (if applicable)	Group Number (if applicable)	
Signature		Date

**If this single application is for multiple providers, the group representative signing above attests to authority to represent the attached list of providers. On this attached list, please include the provider(s) name, the provider(s) Id number(s), and applicable tax ID(s).*

Glossary of Terms

Attending Provider (AP) - The primary provider treating an injured worker. Attending provider has become an umbrella term covering both people licensed as physicians, physician assistants, ARNPs, and people licensed as doctors, such as chiropractors and naturopaths.

Case Note - The Case Note (or SHSC Case Note) is where all action the SHSC took on the claim is documented for billing. This is what is imaged into the claim file to make sure the CM and others know what the SHSC did. The Case Note follows the HSC Standard Work structure.

Claim and Account Center (CAC) - CAC is a web-based and user-friendly system where authorized users can obtain claim information and imaged documents from the L&I claim file.

Claim Manager (CM) - The CM works with state fund claims to ensure that insurance issues have been settled and claims have been paid out to appropriate parties. They must also ensure that the payments which were made were correct and in accordance with state regulations.

Center for Occupational Health and Education (COHE) – organizations that partner with L&I to provide services to injured workers. Services include coordinating worker care for the first year of treatment, engaging with employers about return to work options, training providers on best practices, helping providers implement best practices in their office(s). Find more information about COHES at: **www.Lni.wa.gov/patient-care/health-care-incentive-programs/centers-of-occupational-health-education-cohe**

Health Services Coordinator (HSC) - HSCs work in a COHE, tracking specific claims to ensure early return-to-work services, care coordination, and improved outcomes of workers. HSCs act as a liaison on behalf of the attending provider, worker, employer and CM. HSCs also help APs, workers and employers navigate the workers' compensation system. HSCs perform services for all claims initiated and/or treated by a COHE provider during that period.

Initial Evaluation & Coordination (IEC) - The IEC is a process which includes a series of steps. It's a comprehensive, billable service comparable to the providers E/M (Evaluation and Management) code and is not time-based.

Limited English proficient (LEP) - LEP refers to customers who do not speak English as their primary language and who have a limited ability to read, speak, write or understand English and entitled to language assistance with respect to a particular type of L&I service, benefit, or encounter.

MAPping - MAPping is the term used at L&I for motivation and action planning that claim managers use when engaging with the worker. It involves speaking with the worker to uncover their motivation for returning to work, uncovering barriers that may be prevent RTW, and forming a plan to address those barriers.

MAVEN - MAVEN is the term for the care coordination system within OHMS that HSCs use when they work their claims.

Occupational Health Management System (OHMS) - The Occupational Health Management System (OHMS) is a web-based computer system that will provide case-management tools to help coordinate services for injured workers.

Question Package - A group of questions or information sharing a common theme. The term used by L&I of 'question package' is equivalent to 'screen' which appears to be the term used by COHE users.

Surgical Health Services Coordinator (SHSC) - SHSCs track L&I claims to ensure early RTW and improved clinical outcomes for injured workers referred to surgery by their AP. They act as liaison between the attending provider, surgical provider, worker, employer, claim manager, and vocational service providers. SHSCs perform services for all State Fund claims referred to surgeons participating in the Surgical Best Practices Pilot.

Vocational Rehabilitation Counselor (VRC) - VRCs help individuals deal with the career-related effects of physical and mental disabilities, which may have resulted from accidents, illnesses, injuries, birth defects or disease.

Upon request, foreign language support and formats for persons with disabilities are available. Call 1-800-547-8367. TDD users, call 711. L&I is an equal opportunity employer.

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