# Draft Minutes (*actions taken*)

**Members present:** Drs. Friedman, Harmon, Lang, Chamblin, Howe, Thielke, Haines, Seaman, Lim, Butler, Codsi  
**Absent:** Drs. Leveque and Carter  
**L&I staff present:** Morgan Young, Gary Franklin, Joel McCullough, Lee Glass, Nicholas Reul, Zach Gray, Simone Javaher, Jevahly Wark, Vickie Kennedy, Cheri Ward, Ryan Guppy, Karen Jost, Nikki D’Urso, Susan Abolafya, Ryan Schmautz, Susan Campbell, Sarah Martin, Lyn McClendon  
**Attorney General Office staff present:**  
**Public Attendees:** Leigh Haley, Jerri Wood, Ken Smith, Chey baker, Jamie Hodge, Janice LeGros, Kaethe Long, B. Mills, Terri Smith-Weller

<table>
<thead>
<tr>
<th>Topic</th>
<th>Discussion &amp; Outcome(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome and Introductions</td>
<td>When a quorum was present, Dr. Friedman called the meeting to order and introduced Kim Wallace MBA, L&amp;I’s new Medical Administrator, and Dr. Jason Fodeman, L&amp;I’s new Associate Medical Director.</td>
</tr>
</tbody>
</table>
| Recap of ACHIEV (Karen Jost) | Topic discussion:  
- My L&I enters into a secure system, demonstration provided and was given positive feedback  
- Standardization in care coordination has led COHE’s to enhance and change to include best practices  
- Physical Medicine Progress Report was presented and discussed  
Discussion: COHE concerns regarding claims management should be directed to Sheri Ward. |
| Lumbar Spine Surgery Subcommittee Update (Chris Howe) | The first subcommittee meeting was held on March 20th. Initial introductions and orientation to writing Medical Treatment Guidelines was provided by Dr. Howe, subcommittee chair. Dr. Howe spoke to the difficulty of members from Eastern WA attending telephonically, however pointing out the importance of having a wide range of providers present from all over WA.  
**Approach to the guideline development is as follows:**  
- Fusion  
- Decompression  
- Discuss pathology  
- Most accepted spondylolisthesis  
- Non-operative management  
- Update Cauda Equina and SI Joint Fusion Guidelines  
**Important points that will be of value to overall discussion:**  
- Injured workers that anatomically meet criteria for surgery, but are in poor condition pre-operatively  
- Addressing the guideline becoming an impediment to expectations  
- Guideline algorithm may give the injured worker options for surgery and will not encourage non-operative pre-work  
- Pre-operative first steps that can help create better outcomes.  
**Discussion:** Recommendation made to review Fitness for Surgery with a multidisciplinary approach during all operative phases. |
| **Centralized Scheduling System for Interpreter Services (Susan Campbell)** | SSB 6245 requires L&I to review the payment and scheduling of interpreter services. Meetings were held around the state last fall with interpreters and providers to gather input on the current system for providing interpreter services to injured workers. In March, the Interpreter Project Steering Committee decided that L&I will release a Request for Proposals (RFP) for a scheduling firm. This scheduling system will allow providers to go on-line and request an interpreter. The decision has not yet been made when providers can request a specific interpreter or when or if a provider can schedule an independent interpreter outside of the scheduling system. L&I staff have been meeting with interpreters, workers, and providers to obtain feedback on the new scheduling system. Discussion: The IIMAC members requested the following requirements for the scheduling system.  
- Instances when a specific interpreter is preferred:  
  - Sensitive subjects and appointments  
  - When an interpreter is known to be capable of providing high quality services for medically complex subjects  
- Local areas, clinics require services for walk-in appointments.  
  - Currently, some providers have established relationships with interpreters or agencies that are able to provide timely in-person interpretation services for things like walk-in appointments  
- Ensure that any and all changes are communicated well to the affected stakeholders  
- Prioritize ease of use for provider staff, who may not have the time to figure out how to use a new, complex system for interpreter services  
- Telephonic interpretation is not always viable for use (lack of phones available or phone reception inside the hospital/clinic, etc)  
- Prioritize quality control, and the ability to monitor and track quality.  
  - This includes a method of limiting certain interpreters from accessing the system and interacting with providers if they have a record of poor conduct/quality of service |
| **Spinal Impairment Rating Sheet Update (Joel McCullough)** | History and background of the Spinal Rating Worksheet were presented, in 1974 the Spine Rating System was developed. In 1998 the Doctor’s Worksheet for Rating Cervical and Cervico-Dorsal Impairment and Dorso-Lumbar and Lumbo-Sacral Impairment were created for use in rating impairment. In 2018 L&I decided to discontinue the spine worksheet, as pointed out in 2016 the worksheet and WAC do not correlate. The expectation is that providers use the category rating in WAC language in place of the worksheet. The plan going forward is remove language specific to the Spinal Rating Worksheet from the Medical Examiner’s Handbook (MEH) and Washington Administrative Code (WAC). L&I is forming stakeholder groups and working with the Assistant Attorney’s General office to update WAC language. The effective date for this change is June 1, 2019. Discussion: The 5th Edition MEH will not reflect this change and plans are in place for training in May. L&I has communicated this change to the organizers. |
| **Distal Clavicle Resection Update** | I presented information regarding the impairment rating for distal clavicle resection (DCR) arthroplasty. Rationale and justification was presented to allow 10% upper extremity impairment for DCR. Some were concerned that 10% upper extremity impairment was too high, given that function generally improved after surgery. Note: In the AMA Guides in |
### Acupuncture Rule – Update (Zach Gray)

The acupuncture CR-103 will be filed on April 30, 2019. The last day of the pilot will be May 31, 2019 and the CR-103 will be effective June 1, 2019. This will mean that there is no gap in services. Non-pilot L&I providers can begin treating with acupuncture on June 1, 2019. Providers that are new to treating injured workers will need to apply for a provider number to be paid for their services.

### Master’s Level Therapist Update (Zach Gray)

Training modules are in development for the MLT and the pilot project. The goal is for all potential and current providers to have a basic understanding of workers compensation which is a gap for most. If the modules prove to be effective, then it may be offered to other interested providers. There are currently various levels of development and the committee will continue to provide updates to the committee. The original target start date was July 1st, however the implementation of Provider One has pushed out the start date. It has not been decided how many providers to utilize for the pilot and the geographical distribution of the pilot. At this time there are roughly 12,000 MLTs in the state. Consideration for training and credential requirements are still undecided, as well as utilization. A meeting is set for early May to talk with stakeholder groups, and discussion topics will include payment policy, training, and level of efficiency.

### Chemically Related Illness – Follow-up (Nicholas Reul)

Labor and Industries will be designing a written survey and delivering it to members of our state’s occupational health community including physicians board-certified in occupational and environmental medicine, and industrial hygienists who could perform exposure assessment. The purpose of conducting the survey is to better understand the barriers and needs that could be addressed to improve access. We intend to maintain ongoing coordination with IIMAC and solicit the committee’s advice and recommendations on:
- whom to distribute the survey to
- what questions to ask
- particular concerns we should consider when carrying this work out

We intend to use the information gathered from this activity to create and present possible recommendations for action to IIMAC that if implemented would improve access to these clinical services.

### IIMAC Committee Vacancy (Gary Franklin)

Currently IIMAC has a committee member vacancy, since revisiting and clarifying the Bylaws in the last half of 2018, it was decided the vacancy should be filled with either an ARNP or DNP. Given this direction, L&I staff sent letters of interest to various prominent ARNPs and DNPs in the medical community in hopes of gaining nominations. As of the start of this meeting L&I has received 2 response inquiring more information. At this time both candidates are working to provide the required documents for presentation to IIMAC.

### Physical Medicine Progress Report Discussion (Sarah Martin & Morgan Young)

An update was presented on the Physical Medicine Project. The project has created a draft physical medicine progress report form, an authorization model redesign, and best practice resource. These target improvements in the three best practice areas of functional tracking, patient engagement, and communication. Looking at ways to reduce confusion and streamline the authorization process. Members provided feedback regarding both the draft form and authorization conceptual model.

Feedback highlights included:
- Benefit of having the total number of therapy visits
- Preventing extra documentation review and steps by the attending provider when feasible
- An ideal preference to have a graphic representation of ongoing metrics to include progress and pain levels
- Include objective measurements option for all patients