

May 26, 2006

Fred Bruyns
Workers' Compensation Division
350 Winter St NE
Salem, OR 97301

Re: Proposed amendments to Division 10 and Division 60 rules

Dear Mr. Bruyns:

SAIF Corporation offers the following testimony on the proposed rule changes.

436-010-0220(2) – Choosing and Changing Medical Providers – added to this rule, “...When the attending physician or authorized nurse practitioner refers the worker to a specialist physician, the referral must be written. Unless the documented referral limits the referral to consultation only, the referral is deemed to include authorization for the specialist physician to provide or order all compensable medical services and treatment he or she determines appropriate. ”

Comments: This change may be intended to address Attending Physician (AP) to surgeon referrals and the confusion around who is authorized to do what. However, this modification would make the coordination of care more difficult as well. We recommend the addition of the following sentence:

“Nothing in this rule diminishes the attending physician’s responsibility to fulfill all the responsibilities of an attending physician, including reporting to the insurer, authorizing time loss, and coordinating care.”

436-010-230(2)(b) – Consent for employer to attend medical examination.

Comments: The rule proposes that a consent form for a worker to approve employer attendance at a medical appointment “must be written in a way that allows the worker to understand it.” We agree that every effort should be made for any required form to be understood by the worker.

We understand that the department used to have a form for this purpose. We believe that the department should prescribe a form, thus eliminating any debate about whether an insurer’s form meets the standard in the rule.

Alternatively, if the department does not adopt its own form, we are concerned about the ambiguity in the proposed rule. We do not know whether the department intends

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the form to be produced in a language that the worker would understand. We attempt to do this whenever it is feasible, but the rule could be read to require the form to be translated into any language or dialect, no matter how obscure. We assume this is not the department's intent and the rule should be clarified accordingly.

436-010-0230(6) – Medical Services and Treatment Guidelines – Change in rule would allow dispensing of medications from physician offices beyond the initial 10 day supply as written in the current rules.

Comments:

- Physicians treating workers' compensation injuries often lack access to the injured worker's medication history. That history is usually available through the worker's pharmacist's database and the Pharmacy Benefit Manager (PBM) databases. Therefore medications may be dispensed that are contraindicated (drug to drug interactions) or duplicative, as they are already prescribed by another physician.
- Case management is made more difficult. Not all of the information about medications dispensed will be available when dispensed in the provider's office. Specific pharmacy data fields, for example days' supply and National Drug Codes are not a part of the CMS 1500 forms used in medical practices. This lack of specific information complicates care and medication management.
- In 2003 the Pharmacy Task Force was convened by the WCD Administrator, John Shilts, to analyze pharmacy costs. The Injured Worker Ombudsman's Office informed the task force that they received very few calls from workers complaining about access to medications, even on their first fill. Recently, the Ombudsman's Office informally tracked medication access related calls from injured workers over a 4-6 week period. They received no calls on medication access during that time.
- This dispensing process would require a visit to a physician's office to refill a prescription. This could increase unnecessary office visits.
- On one recent billing from a physician who dispenses medications, the injured worker was given prescriptions to fill at a pharmacy (because they were not in the physician's dispensing inventory) and two prescriptions were filled by the physician. One of the medications dispensed by that physician was for Hydrocodone with acetaminophen 7.5/500mg, 60 tablets. The physician billed us \$31.11. Under the proposed rule, the provider would be reimbursed at the WCD fee schedule for \$17.43. If the worker had the prescriptions filled with their other prescriptions at a pharmacy in our PBM's network, that same medication would have cost us \$4.95. Even though the medication dispensed by the physician was generic and lower in cost than a brand medication, the markup on generic medications is extremely high. This one medication would cost many times more than we would normally pay.
- Repackaging of medications has become a big business. (See www.physicianstotalcare.com) There are many firms marketing directly to

physicians, who term the direct dispensing practice “a revenue builder”. Physicians Total Care advertises that direct dispensing assures accuracy, saves patients time, cuts medication costs and increases practice revenue. There is no evidence to support the first three points, and physician revenue enhancement is not a goal of the workers’ compensation system.

- Why is this rule change proposed? We could identify no need for the expansion of practitioner dispensing from the Ombudsman’s Office, our worker contacts, worker surveys or our MCOs. There is no evidence of a problem in the existing rules on physician medication dispensing.
- Workers have many pharmacies to choose among to fill their prescriptions. This rule change would indirectly reduce choices for the worker. Even if the physician told the workers they could fill the prescription elsewhere, it is common that injured workers and patients in general, do not question their physicians.
- Once this type of practice is expanded, its appeal increases among more prescribing practitioners. This practice is growing nationwide and would spread among practitioners in Oregon at additional cost to the system without any demonstrated benefit.
- Medical Quality Initiative (MQI) - This proposed change is contrary to the goals of MQI to provide high quality medical services while controlling costs. Increasing the sources of medications complicates care management, may affect patient safety, would only cover certain medications carried and dispensed so many workers would still make a trip to their local pharmacy, and would clearly drive up the costs of prescriptions by our calculations from 100 to 700% over the costs we pay today for medications. Last, there is no data-driven reason to expand this practice. Evidence-based decision making is another important tenet of the MQI.
- We strongly disagree that this rule change will have a positive fiscal impact on the cost of the system. There is overwhelming evidence that drugs dispensed by physicians cost more than drugs dispensed at a pharmacy. We would be happy to provide additional information in support of this position. With pharmacy costs growing at a faster rate than many other health care costs, it would be irresponsible to add to this cost escalation.
- For the aforementioned reasons, we ask that the department not implement the proposed rule. We also ask the department to revisit the current rule that permits a 10 day initial supply of medications. The earlier rule allowed for emergency prescribing when necessary. The current rule allows dispensing for a longer period of time at a rate that serves to increase pharmacy claim costs.

436-010-0265(2)(d) – Independent Medical Examinations – 4th IMEs and associated penalties. The rule change states in part that insurers shall not use any IME report for any claims processing purposes and the report shall not be considered in any subsequent proceedings if the report is challenged and there is a finding that the IME exceeded the limits of 3 IMEs without prior approval from the director.

Comments: We agree that insurers should be subject to civil penalty for any clear violation of statute and rules. However, we question the department's authority to dictate what documents are admissible in a legal proceeding conducted by the Workers' Compensation Board.

We have three main concerns about this proposal. First, what constitutes an IME is not totally clear. An insurer may proceed in good faith to schedule an IME believing it to be the third IME in the claim. This examination may produce uncontroverted medical information that changes the direction of the claim. At a later date, a worker's representative may assert that an examination that took place months, or years, earlier in the claim was, in fact, an IME. If the worker prevails in that contention, the current examination would be wiped out, despite the validity of its findings.

Second, there appears to be no time limit for the worker to raise the issue of an invalid IME. This leaves the door open for a worker's representative to go back many years to search through the prior claim record for any prior actions that could be used to invalidate a subsequent IME report.

Third, there is no evidence of abuse that would justify this onerous and unauthorized expansion of the rule.

We recognize that Senate Bill 311 requires new procedures governing IMEs, and we concur that the perception of abuses needs to be addressed. We believe there is a simpler, and more effective, way to control excessive IMEs. The appointment notice sent to the worker could include a statement to the effect that if the worker believes the IME exceeds the authorized number, the worker must appeal to the department before the examination. The notice would also encourage the worker to call the Ombudsman's Office for advice. At the most, the worker should have 60 days to raise the issue.

Additional concerns:

- The rule states "any" IME could not be used. We assume the intent is to invalidate only IMEs beyond the permitted three. The rule should so state.
- What is the practical application of this rule? If a challenge is successful, what exactly would the insurer be required to do? How does the insurer undo whatever claims processing activity that has occurred?
- There is no definition of "claims processing purposes". Exactly what does that mean?

OAR 436-060-0095(5) We recommend the Division 60 rules be modified to include a provision that the Notice of Appointment letters inform workers who are attending

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psychological IMEs that the physician has the right to refuse having an observer present during the exam. This would be consistent with OAR 436-010-0265 (15)(a).

We appreciate the opportunity to submit comments on the proposed rules.

Sincerely,
Chris Davie
Vice President of Corporate Policy and External Affairs