Workers' Compensation Advisory Council

Friday, August 5, 2016
Room 307 - LOB – 9:00 a.m.

Present: Ms. Margaret Crouch, Chair; Mr. William McQuillen, Vice Chair; Ms. Sally MacFadden; Senator Gary Daniels; Ms. C.J. Stone; Dr. Douglas Goumas; Ms. Eileen Bernard; Representative Brian Seaworth; Mr. Martin Jenkins; Ms. Merideth Schwab.

Absent: Ms. Marian Mitchell

Call to Order – The meeting was called to order by Ms. Crouch at 9:05 a.m.

Review & Action on June 10, 2016 Minutes – The minutes were reviewed by the Council.

Representative Seaworth motioned to accept the Minutes of the June 10, 2016 meeting and Senator Daniels seconded. ***The motion was passed unanimously.***

Managed Care

Injury Management Facilitator – Brooke Doyle, RN (Liberty Mutual)

After a brief discussion, Ms. Crouch made a motion to approve Ms. Doyle as a Management Facilitator, seconded by Senator Daniels. ***The motion was passed unanimously.***

Department Updates

Insurance— Ms. MacFadden reports that the NCCI has made a rate filing. The change to Voluntary Loss Costs is -9%. The change to Assigned Risk Rates have been filed as -9.4%, which represents a substantial decrease. The Insurance Department has not started reviewing the filing yet as it has just come in and will be reviewing it over the next month and there will be a hearing held at the Insurance Department on October 4, 2016 at 10:00 a.m. in Room 274. After that, the Commissioner of the Insurance Department will issue his opinion about whether it will be approved as is or with changes. The NCCI is sending out an Executive Summary and the Department of Insurance will post the Executive Summary to its website. The Insurance Department will also be issuing a press release.

The Insurance Department has gotten a couple of requests to look at providing some kind of workers' compensation work-type coverage to volunteers. The volunteers are excluded from the definition of employee so cannot be brought under the workers' compensation law but there is an endorsement called the Voluntary Compensation Endorsement that can be used to cover volunteers under a similar type of law where volunteers would give up the right to sue if they want to get workers' compensation-type of benefits. The Insurance Department has taken a look at the endorsement and they are telling their assigned risk carriers to use the voluntary compensation endorsement if their employers want to use it to cover volunteers. The Department of Labor would not hear hearings on this. If the volunteers decided

not to exercise their right to the workers' compensation benefits, then one could file a lawsuit under any other type of insurance the employer may have.

Labor— Mr. Jenkins reported that the Department has one request for hearing under § 24 for the reasonableness of medical bills. The hearing has not been heard yet and there is still a possibility that a resolution may be reached.

Legislature— Representative Seaworth reports that House Members were asked not to do business unnecessarily during the summer so it has been completely quiet. He does expect that they may do something with Interim Study bills in the fall when they meet again. Also, one of their bills formed a study committee, and the issues were soft tissue damage and the first responder and seeing if that can fit under workers' compensation. There is a committee that has been formed by legislation. The appointments have not been made but the House fully intends to have that committee in and to discuss it seriously.

Senator Daniels reported that it has been quite on the Senate side as well, so nothing to report at this time.

Old Business –

Managed Care Lab Rules – Chapter Lab 700

Public Hearing – A Public Hearing was held on July 27, 2016 with regard to proposed changes to the Managed Care Rules. There were speakers present presenting oral comments and concerns. The rules for rule-making call for the public hearing to be one-sided. This allows the public to have input but not to have questions answered. At this meeting today, it is allowed to have discussion on both sides.

There was considerable discussion at the Public Hearing of whether PT and OT should be an either-or or separately be required as part of the network. There was also conversation about acute care hospitals and why the recommendation was made to remove that as a requirement of the network in a managed care program.

Dr. Goumas asked why the OTs and the PTs are being lumped together, they are two distinct entities. Ms. Bernard responded that there was not sufficient OTs to cover the entire state and to have two in each area. Also, that there were not sufficient hand surgeons identified, two in each area, so what was attempted by the state was to change the requirements so not to have to make exceptions to get them all approved because they could not meet the requirements. And allowing for the opportunity for Managed Care Programs to contract with providers not on this list, providing that it still allows for choice for the injured employee if those providers are available within a certain geographic area where the injured worker is.

Carl Moskey from Concord Orthopaedics indicated that he does not understand the elimination of hand surgeons as a requirement of the network. Access to hand surgeons is important. Ms. Crouch responded that according to the current rules because they service every county in the state but there may not be two hand surgeons in every county, then no managed care plan could be approved because they do not exist in the counties that they physically need to be in in order for the plan to be approved. None of this is saying that we do not believe that hand surgeons are not necessary or important in the treatment of work injuries. It is recognition that in order for a managed care plan to be approved this is the minimum that needs to be included. You can contract with other providers and assuming that they are within a 25-mile distance from an injured worker, the managed care program can obligate the injured worker to treat within the

network for hand surgery if there are two if they still maintain that choice. Another question was posed that if a patient in the North Country has a hand injury and needs surgery and you have a network in which there is not the requirement to have a hand surgeon there anymore, will that patient be treated by a non-hand surgeon or will that patient go off to another location to be treated by a hand surgeon? Ms. Crouch answered that if there is a recommendation to treat outside the network and to treat with a hand surgeon in Concord, for example, for someone who lives in the North Country, that when transferring care outside of the network is recommended by an in-network provider, recommending a hand surgery be done outside of network, then the rules allow for that to happen. The state does not arrange the networks or get involved in the contracts. Ms. Schwab mentioned that just because they are not in the plan, does not mean that they do not exist in the county; it just means that that provider has chosen not to contract with that MCO. That is why they are allowed to go to an adjacent county to cover that deficient specialty.

Dick Boulet who represents the Physical Therapists Association commented that they feel is a very critical important issue and find no rationale to support the change to have these two providers, physical therapists and occupational therapists, be listed as separate. He believes that it is a critical issue and will challenge it.

As far as acute care hospitals, currently the way the rules read, in order for a managed care program to have an approved network, they have to have at least two acute care hospitals in every county. The requirement is that you have a state-wide program. The fact is that there are not two acute care hospitals in every county. So there are situations where the state has approved managed care program networks that are technically not meeting the requirements of the rules, which means that the rule has not been complied with. There are provisions currently in the rules and in the proposed rules that say if the services are not available within the network, the injured employee can treat outside the network. This is as the rules read now and how the proposed rules would read. A treating physician can treat anything and that has to be provided within the network or not. That is part of the current rules and will be in the future rules.

There was some concern raised by Mr. Potter of the New Hampshire Medical Society of what was being changed in the network may somehow have a negative impact on those injured employees in the more remote areas of the state. The Council responded that treating with a provider that is available to the injured worker outside of the network would not be an issue because they would not fall into the provision currently in the rules that says the carrier is only obligated to pay for treatment within the network unless it fits those other provisions that allows the employee to treat outside of the network. We do not want to have a situation where there is such a small network of providers that carriers are denying payment for treatment simply because they are outside of the network, but yet recognizing that you cannot have a network that includes all of those specialties as they are listed now to be in compliance.

Ms. Minnehan of the New Hampshire Hospital Association voiced some concerns indicating that the changes may discourage contracting, and if a network is being approved that is limited where general surgeons and family practice providers may not be included, then who coordinates the care. There is concern about that; there are other ways to address the standards without excluding providers. Mr. Jenkins clarified that nothing is being excluded; it is just no longer required as basic minimal lists. Ms. Minnehan is also concerned about what is being sold by the carrier to an employer, do they understand what they are purchasing when purchasing workers' compensation policies. She suggests that data is needed and until that data is available, these changes should not be implemented because there are so many concerns of the day-to-day process of how patients will be cared for and the NHHA will continue to object to the changes.
Ms. Crouch indicated that as far as what is being sold, it is a vehicle for an employer who chooses to participate in a managed care plan that includes all of the rules of a managed care plan that satisfies their

obligation to provide medical treatment for a workers' compensation injury. That satisfies their requirement to provide that. What they get is participation in the managed care plan and they get the injury management facilitators and they get all of the other parts of the managed care plan so it is not necessarily something being sold to them as a different policy. It is still the workers' compensation statute, and it is a different part of the statute that allows the employer to satisfy their obligation to provide medical treatment to an injured employee within an approved managed care plan. So all the rules associated with when you can treat outside the network would still apply.

Ms. Crouch added that there is a requirement that the managed care plans be statewide and that was added subsequently. There is nothing to preclude contracting or encourages contracting for all of the reasons that there are network contracts in place. It is for purposes of the managed care program and it is not a different kind of insurance policy, it is a managed care program that the carrier may choose to either contract or have their own, etc., and there have been subcommittee meetings about the proposed rules of which the public is invited to, to clarify what the intent was, and what the issues are that we are trying to resolve with currently having rules that no managed care program can comply with now in the state.

Mr. Jenkins explained that the basic concept is that the employer must provide medical care for the injured worker. It was that the injured worker could treat with whomever they wanted. The bills would be paid. With managed care, the first time the option was, here is a small network that they must treat within and that is all they got. If the treatment is within the network, then they would have to treat within the network. This Board, part of its duty, was to make sure that whatever network as proposed has at least the basic minimum, and anything that was part of the network is also approved and the treatment has to stay within that network. So there is two levels of approval here, the basic absolute minimum that has to be provided plus whatever else that there is to offer so long as there is two in each county and within 25 miles, but any treatment outside of the network, if it is prescribed by the doctor then it is always true that any medical care that the injured worker needs gets provided, it is just that when there is a network they have to stay within the network. If they cannot get the treatment within the network, then they still can go anywhere they want and get it paid for. So the advantage for carriers is to get a large network, pre-negotiate the costs, and bring people within the network because the employers save money. That is always true but the law is not concerned about the savings, but looks to see the minimum amount of care that absolutely has to be there, plus other people in a network, as long as it is sufficiently broad as prescribed in the regulations. Every medical need has to get addressed. Taking acute care hospitals off the list means that all networks are free to contract with all hospitals.

Questions from the gallery: (1) How does an injured worker even access care initially if the family doctor is not within the network? Mr. Jenkins responded that most injured workers with traumatic injuries receive a lot of care not within the network and get covered because it is an emergency. (2) How does the ER doctor determine where the patient can go if they have been educated about this network and they do not have a family practice as listed? Mr. Jenkins responded that the listing of family practice is not that family practice cannot be within the network, it is just not required. (3) Is there any data on denials for treatment outside of the network? Ms. Stone responded that the Department of Labor has not seen any denials from outside of the managed care network for quite some time.

Mr. Jenkins recommended and the Council agreed that there be at least one more meeting of the subcommittee to address public comment and make the changes they think ought to be made. Ms. Crouch would like to get some additional information about the OT/PT availability as to why they should be separate and concerns about whether there is sufficient coverage in the state.

700 Rules Subcommittee Meeting – The next 700 Rules Subcommittee Meeting is scheduled for Thursday, August 18, 2016 at 2:00 p.m. at the Department of Labor to review the

comments submitted by the public as a result of the Public Hearing that previously took place on July 27, 2016. The rules as they stand now will not expire as long as the Department of Labor still actively works on them. The Subcommittee will consider the oral testimony and the written comments that were presented in response to the rules that were in the notice and they will talk about the proposed changes. Then the Workers' Compensation Advisory Council will discuss it further and will need to approve the changes and then onto legislative services, etc.

Definition of Independent Contractor **–** With regard to HB 1697 and the three different definitions of "independent contractor" that were mentioned at the last meeting, Senator Daniels asked Mr. Jenkins to send him the different definitions so that they could be looked at and compared.

New Business – Nothing to report.

The Council scheduled the next Workers' Compensation Advisory Council meeting for Friday, September 9, 2016 at 9:00 am.

Meeting Adjourned-

Ms. Bernard made a motion to adjourn, seconded by Ms. Crouch at 10:14 a.m.